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To provide preventive treatment, counselors from the Division of Vocational Rehabilitation (DVR) worked through a school project to serve adolescents with disabilities which might make job adjustment difficult. During the 5-year project, over 5,000 adolescents were referred; 1,800 or 40% of whom were in the school project; more than 1,000 or 55% were accepted for treatment, and the other 45% were being processed. Compared to clients in the traditional program, clients in the school project were younger, with about half 14 and 15 years old. All received diagnostic services. The most frequent disability was found to be emotional disturbance; the next most frequent were orthopedic impairments and mental retardation. Special treatment facilities offered included a college program, a day care program at a private mental hospital, community workshops for retarded clients, a group therapy program for emotionally disturbed clients and their parents, and a camp for emotionally disturbed clients. Interviews evaluating the project indicated that the DVR counselor played the crucial role in its functioning; ratings of the counselors indicated that the DVR counselor's relationship with the school guidance counselor was important. Of a sample of 91 active clients, most had been referred at age 14 or 15 for psychological problems. Of nearly 2,300 cases closed during the project, only about half were employed and half were closed after referral. (JD)

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PREVENTIVE REHABILITATION

MAR 11 1969

A PROMISE FOR THE FUTURE

EC003652E

A Demonstration Project To Evaluate The Effectiveness Of A Statewide Comprehensive Vocational Rehabilitation Program In The Schools Of Rhode Island.

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
OFFICE OF EDUCATION

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July 1968

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IN MEMORIAM

Edward J. French

1927 - 1966

Edward J. French was Project Director until his untimely death in July 1966. His understanding, interest, and devotion to disabled children led to the initiation of the Rhode Island Division of Vocational Rehabilitation SCHOOL PROJECT.

PROJECT RD-1126

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PREFACE

Since the official termination of the Demonstration Project on June 30, 1967, the Rhode Island Division of Vocational Rehabilitation has continued this project as part of its regular rehabilitation program. The success of the most ambitious special program ever undertaken by the Division is a mandate for all workers in rehabilitation to move forward and strive to achieve new goals.

The success of the Project is almost entirely dependent on the quality of the DVR counselor. The excellent cooperation and harmony between them and existing school department personnel was an important factor in the continuity of this Project. The Project, because of its inherent nature, constantly attracted dynamically oriented young men and women and, despite the high turnover rate among the counselors, the agency was most fortunate in attracting competent replacements. The significance of the counselor's role cannot be overemphasized as is pointed out in this report. Detailed questioning of the personnel in school after school pointed out this most important factor.

The interpersonal relationships developed between the various school departments and the State Division of Vocational Rehabilitation provided an interesting experience in the high quality of treatment that was available to the clients throughout the state. Without the usual competition that often exists among agencies, the Division of Vocational Rehabilitation and the schools have effectively cooperated in meeting the multi-needs of the adolescent client. As a result, the highest possible level of services contributed to making these citizens productive and independent.

For many years orthopedic, hearing and visual cases had the highest rate of incidence in the caseloads of the state. Statistics from this report now indicate that the vast majority of adolescents referred for services had either personality, character or behavior disorders, closely followed by mental retardation or deficiency. It is indicated that through proper services and extensive counseling, optimum functioning may be attained by people with these disabilities.

Through the availability of a new spectrum of services such as vocational training or a four-year Liberal Arts education, accompanied in many cases by medical and psychological services, young men and women from all walks of life were able to improve their standard of living.

Well-motivated clients who have received the many services have found employment as social workers, teachers and librarians; one young man finally completed law school, another is working as an architect. Dependent, troubled people were given the opportunity to muster their own resources, with agency help, in order to become productive, useful citizens.

Although the Project ceased, the school program is continuing to function as an integral part of the Rhode Island Division of Vocational Rehabilitation. It is a dramatic new approach to rehabilitation, a stimulating challenge and a promise for the future.

Deron J. Hazian, Supervisor
Division of Vocational Rehabilitation

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INTRODUCTION

This is a report on a five year demonstration project which was undertaken by the Division of Vocational Rehabilitation. Within the agency it is known as the School Project. It serves the school population throughout the state fourteen years of age and over. This program is one of the most imaginative, exciting and promising innovations in rehabilitation services in recent years.

It is imaginative because it represents a sharp break from the traditional concept of rehabilitation services, and introduces an entirely new concept into the philosophy of the Vocational Rehabilitation Program.

It is exciting because the focus is on early identification of disabilities and "preventive" treatment prior to the time the client enters the labor force.

It is promising because it reaches the client at a young age before the disability has fully developed and provides a wide range of rehabilitative services.

This demonstration project represents a change in the basic philosophy of the traditional program in at least two respects, both equally important. First, the fundamental aim of the School Project has been to seek out potential problem cases at a young age, while the person is still a dependent, and attempt to correct the deficiency prior to the time when the individual will be ready to enter the labor force. Thus the philosophy has shifted to prevention rather than the traditional rehabilitation function.

Secondly, the program has focused attention on emotional and other psychological disturbances which represents a break from the traditional focus on physical disabilities. Thus the purpose of the Project has been to seek out such problems in the early stages of development so as to prevent them from becoming so firmly ingrained in the individual's personality that the client would become permanently disabled. Treatment relies heavily on medical and psychiatric services, and also provides college training for many who otherwise might not have been able to pursue higher education because of their disabilities and/or lack of motivation and resources. However, the primary purpose of the agency continues to focus on preparing the individual client for participation in the labor force.

This Project is an enlargement of a special program which was initiated on a small scale by the Division of Vocational Rehabilitation in 1956. In the beginning the Division assigned a single counselor to the then twenty-nine high school guidance departments in the state. This counselor visited the various schools and discussed the proposed program with the guidance personnel, school nurses and in some cases with the principals. It was soon learned that the schools were having severe problems with youngsters who were either physically handicapped or were emotionally disturbed, and while the schools could readily identify the presence of such problems they did not have any treatment facilities available. Thus the schools were ready and anxious to accept any assistance that DVR could provide. It soon became evident also that the sixteen year old age limit of the program in its initial stage would miss many of the problem cases in the school who were in need of help.

During the next few years increased attention was placed on this aspect of the program by assigning additional counselors and thus decreasing the number of schools served by each counselor. Consequently the counselors could work more closely with the school and could visit each one more frequently. From the use of the program by the schools it soon became apparent that there was a real need for DVR type services for this segment of the population.

In 1960 the Regional Meeting of the Rehabilitation Agencies in New England was held in Providence. Two of the participants, who later were to be largely instrumental in broadening the scope of the program, were the late Congressman John E. Fogarty and Miss Mary E. Switzer, National Director of the Office of Vocational Rehabilitation. The focus of attention at this meeting was on the early efforts of the Rhode Island Division of Vocational Rehabilitation to work with the schools of the state. Although the program was not fully developed, even in the embryonic stage it represented a new concept in working with youth. The program was accepted with enthusiasm by the conference participants. It provided a challenge for the future. Consequently it was decided that a demonstration project should be established, and the age limit reduced to fourteen years so those with disabilities could be identified and assisted at an early age.

The interest at this conference provided the impetus for the establishment of a formal Research and Demonstration Project (VRA Grant No. RD-1126-G). This was a Demonstration Project to Evaluate the Effectiveness of a Statewide Comprehensive Vocational Rehabilitation Program in the Schools of Rhode Island. The Project was to extend over a five year period. The Project was under the direction of one of the original counselors who had started to work with the schools several years earlier. It was designed to serve the handicapped adolescent population in the schools of the state from age fourteen through twenty-one years.

One of the goals of the Project was to develop in the schools the concept and practice of preventative referrals to the community agencies and to develop between the schools and these agencies an established habit of communication. All types of physical and emotional handicaps which could be considered as potential vocational handicaps were to be served, thus placing emphasis on its "preventive" orientation. More specifically, the program was designed to accomplish the following objectives:

1. To demonstrate, evaluate, and determine the kinds of facilities and services that will best meet the needs of handicapped students in Rhode Island.
2. To insure early and more adequate identification of pupils with vocationally handicapping conditions.
3. To demonstrate the role the Division of Vocational Rehabilitation can play:
    (a) In assisting school personnel in becoming more sensitive to the various disabilities and the limitations they sometimes impose upon a student's total school adjustment.
    (b) In making school personnel more conscious of handicapping

conditions which in the school may not be considered handicaps, but which are potential vocational handicaps in a student's post-school career.

4. To determine and evaluate the roles of the various educators in dealing with handicapped students; e.g., the teacher, the special educator, the guidance counselor, the school psychologist, the school administrator, and the Division of Vocational Rehabilitation.

5. In cooperation with guidance, special education, vocational education and adult education, to identify and evaluate needs of handicapped students and assist in promoting increased local efforts in meeting these needs.

All services offered to handicapped students under this Project were offered with the intent of keeping the student in school as long as possible. In the case of drop-out or graduation, services were offered to facilitate the client's entry into the labor force. The program attempted to reduce the incidence of drop-out among handicapped students.

The School Project made the school staffs more aware of the services available to handicapped students through the Division of Vocational Rehabilitation and other community agencies such as Butler Health Center, Community Workshops of Rhode Island, Crippled Children's Division, Rhode Island Hospital Hearing and Speech Center, and other programs. Also, the counselors pointed out the relationship of these and other community facilities to school programs.

This program provides any student between the ages of fourteen and twenty-one who has a handicapping condition which can be considered a potential vocational handicap, as defined in the Rhode Island Division of Vocational Rehabilitation State Plan, with any or all of the services routinely offered by this agency. Services provided include:

1. Medical diagnosis (general medical exam, specialist exam, etc.); a complete medical work-up was to be offered to determine the nature and extent of the disability.

2. Medical treatment (surgery--including open-heart, orthopedic, and cosmetic, psychotherapy, hospitalization, etc.); any treatment which could possibly reduce or eliminate the disability was to be offered to each student.

3. Artificial limbs, hearing aids, artificial eyes, and other prosthetic appliances were to be purchased where indicated.

4. Individual counseling and guidance in conjunction with the school guidance program.

5. Vocational placement and/or psychological testing to assist the student in making a vocational choice and to supplement the schools' testing program.

6. Training on a post-school basis to attain the student's vocational choice. Tuition for college, trade school, business school, or

on-the job training could be paid.

7. While in training, the Division could pay for room and board, books and supplies, and other training materials.

8. Maintenance and transportation could be provided during treatment or training.

9. Tools, equipment, licenses, or initial stocks and supplies to start the student in a small business could be authorized if this was a realistic and practical endeavor.

10. Help in placement in a job commensurate with the student's physical and mental capacities when he was ready for full-time employment.

11. Follow-up to ensure that the student and employer were satisfied with the placement. Each student was to be followed for at least thirty days after he started a job. The emotionally disturbed student and the mentally retarded student were to be followed for longer periods.

All of the above listed services were provided in accordance with the Vocational Rehabilitation Division's policies, its State and Federal Legislation and Regulations, and its State Plan.

To carry out this Project ten DVR counselors, under the direction of two supervisors, were hired and assigned to the forty-one school systems in the state, as shown in Map 1. Each counselor was assigned to specific schools which he was to visit on a periodic basis. Initially the ten counselors were assigned to school systems in the same geographic area, primarily to facilitate travel. Each counselor was given a total population of about 6,500. However, after slightly more than a year's experience, it was found that assigning counselors to approximately equal school populations was not the most feasible plan. It was noted the number of referrals from the schools did not depend so much on the size of the population, but rather referrals varied substantially by the type of population. For example, the incidence of disability appeared to be higher in urban areas than in suburban areas. Also, guidance seemed to be more emphasized in the urban sections than in the rural. In addition, each school system differs in its' method of operation as each school differs in its' approach to administration, guidance, special education, etc. These differences had to be taken into account in estimating the potential caseload for the school. How the assignments were divided is shown in Table 1. Attempts were made to equalize the workload by considering not only size of population to be served, but the type of population in the area and the distances that must be traveled by the counselors in visiting their schools. Thus as the distance from the central office increased, the size of population to be served decreased. Each guidance department was to be visited on a weekly or a bi-weekly basis depending upon the size of the school, the geographical area, and the demand for referrals.

The counselors assigned to the program were quite young. Only one had had previous counseling experience with the agency. The new counselors were attracted to the program because it was new and they liked the challenge it offered. The general lack of experience of the counselors initially posed a problem in that they had to be trained and oriented to the procedures to be

MAP OF THE STATE OF RHODE ISLAND

SHOWING SCHOOL DISTRICTS

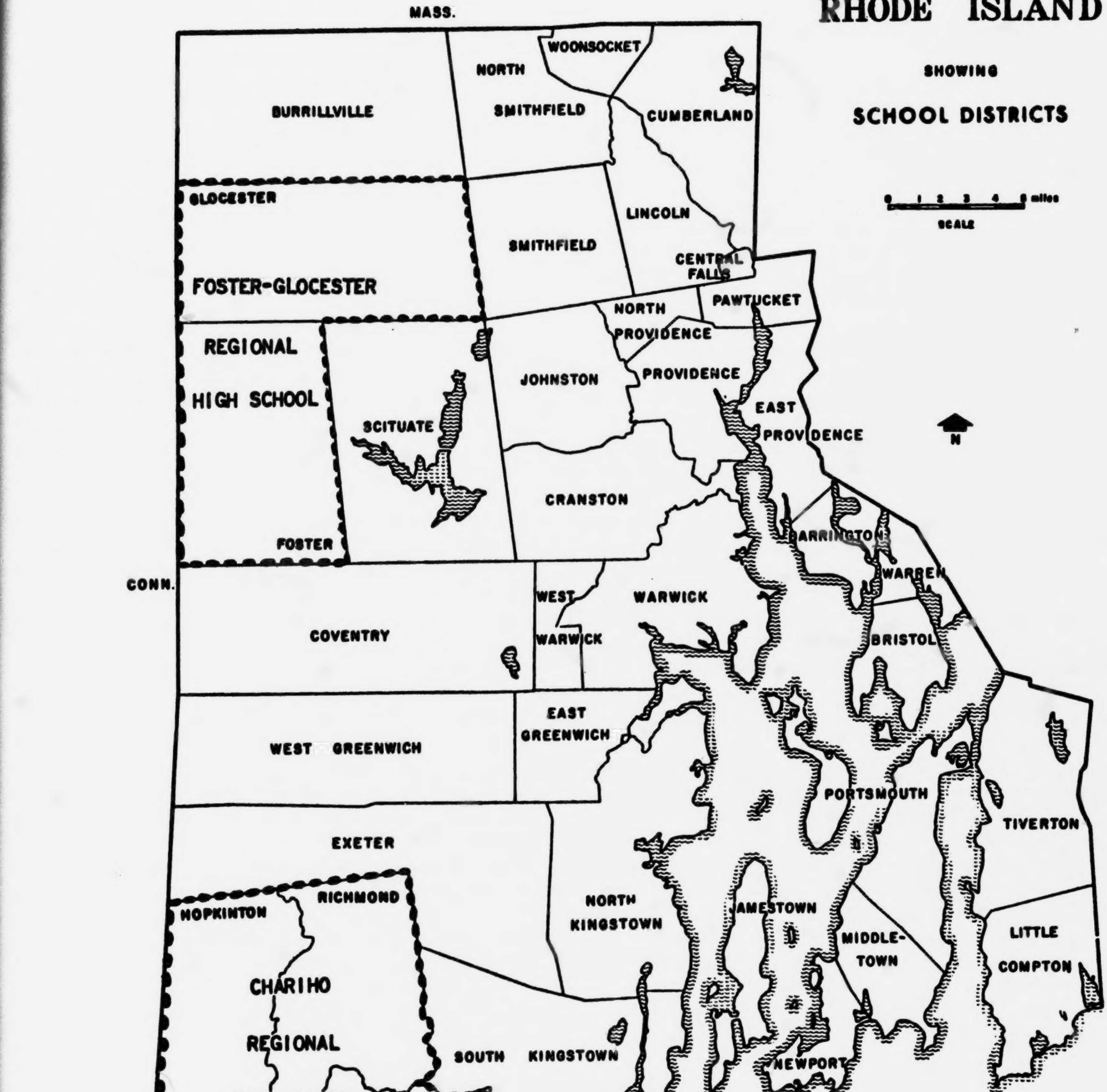
MASS.
CONN.
BURRILLVILLE
NORTH SMITHFIELD
WOONSOCKET
CUMBERLAND
GLOCESTER
FOSTER-GLOCESTER REGIONAL HIGH SCHOOL
FOSTER
SMITHFIELD
LINCOLN
CENTRAL FALLS
PAWTUCKET
NORTH PROVIDENCE
PROVIDENCE
JOHNSTON
SCITUATE
EAST PROVIDENCE
CRANSTON
BARRINGTON
WARREN
WARWICK
WEST WARWICK
COVENTRY
BRISTOL
EAST GREENWICH
WEST GREENWICH
PORTSMOUTH
TIVERTON
EXETER
HOPKINTON
RICHMOND
CHARIHO REGIONAL HIGH SCHOOL
NORTH KINGSTOWN
JAMESTOWN
MIDDLE-TOWN
LITTLE COMPTON
NEWPORT
SOUTH KINGSTOWN
CHARLESTOWN
NARRAGANSETT
WESTERLY
BLOCK ISLAND
NEW SHOREHAM
0 1 2 3 4 5 miles
SCALE
N

TABLE 1.

D. V. R. COUNSELOR ASSIGNMENTS

SCHOOL PROJECT

Counselor	Areas and/or Schools Assigned - - Age Group: 14-20			Estimated Referral Population
Bond	PROVIDENCE:	Four Public High Schools		19,215
Tarmey		Four Public Junior High Schools and Ladd School		
Heaney		Four Public Junior High Schools		
Long	Barrington Bristol Middletown	Newport Portsmouth Little Compton	Jamestown Tiverton Warren	10,082
Costa	East Providence and Pawtucket			10,197
Dunn	Central Falls, Lincoln, Cumberland & Woonsocket			7,815
Cicilline	Cranston, North Providence and Johnston			8,061
Campbell	Burrillville Smithfield Providence:	Scituate Glocester Children's Center & Parochial Schools	Foster No. Smithfield	3,197
McKenna	Coventry East Greenwich	Warwick West Warwick	Exeter West Greenwich	9,790
Testa	Charlestown Narragansett	No. Kingstown So. Kingstown Hopkinton	Richmond Westerly	3,955

followed in the program. The new counselors had to become aware of the rehabilitation reference as well as the mechanics of the case process. To meet this need in-service training was offered by the Project Supervisor and the psychiatric consultant. In addition, all of the new counselors attended a one-week orientation period co-sponsored by the Regional Office and Boston University at Osgood Hill, Massachusetts. At the time two of the new counselors were already in graduate counseling programs; six others enrolled in similar programs. It was the experience gained by this training that enabled the new counselors to quickly assimilate the overall concepts and practices of the agency.

To promote the Project throughout the state the Project staff actively engaged in a number of public relations programs. For example, the staff accepted a large number of invitations to describe the program to P.T.A. groups throughout the state. The staff also spoke to civic and luncheon groups such as the local Lions and Kiwanis clubs. The staff widely participated in radio broadcasts and in panel discussions at meetings and conferences throughout the state to inform people of the services available under the program. Most of the staff efforts were devoted to the schools for it was through schools the referrals were expected, since it was there that such problems would become evident.

To get the Project under way the Project Supervisor, along with the counselor assigned to the area, visited the schools throughout the state. They met with the guidance directors, the school principals, and in some cases with the school nurse to describe how the program would function, the type of clients the agency could accept, how the referrals were to be made, and the kinds of services the agency could provide.

As a method of operation it was agreed that referrals would be made by members of the school guidance departments, the school nurse or the principal's office. When a potential client has been identified the school assumes the responsibility of meeting with the parents to describe the DVR program and what procedures should be followed to have the client participate in the program. If the parents agree the case should be referred to the agency, an appointment is scheduled for the counselor to meet with the parents at the school and secure written consent for the child's participation.

After the client has been formally referred to the agency he is given a complete diagnostic examination. The services provided by DVR cover a wide range, but local physicians and facilities are used whenever possible. Following the diagnostic examination the case is accepted for treatment if it meets the following three criteria:

1. A handicapping condition exists; it can be either physical or emotional,

2. The handicapping condition, if uncorrected, would limit the client's future employment, and

3. The handicapping condition can be treated (helped) by the services provided by the agency.

If the above conditions are met the DVR counselor formulates with the client and his parents a tentative plan of treatment or training. At this point the client may or may not accept the services offered. Experience has shown that nearly all of the clients that reach this stage take advantage of the services offered. For example, of the 2,500 clients being served by the agency during the period July 1965 through June 1967 only five clients had dropped out of the program at this stage. Another twenty-seven clients had dropped out for a wide variety of reasons following the diagnostic examination but before a plan for treatment or training had been worked out. This high retention rate suggests this method of identification of clients for services is very effective. However, as will be pointed out later, the effectiveness of this method depends on the quality of the DVR counselor and the interpersonal relationships that exist between the counselor and the school guidance directors. Once accepted the clients may see the counselor whenever he is at their school or they may prefer meeting with the counselor at his office. The counselor is also available to meet with the client's parents and frequently can interpret the client's disabilities to the family. In working out diagnostic evaluations and programs for treatment the DVR counselor has available a number of specialized consultants.

Since its inception the School Project has utilized the services of an organized consultant staff to review medical and psychiatric cases. This staff consists of an internist, a psychiatrist, a psychologist, and a dental consultant. The internist is available to the counselors three hours a week, the psychiatrist is present for seven hours, and the psychologist is available to the counselors for four hours at the agency office. The dental consultant is not used on a regular basis, but is always available to the entire counseling staff when the need arises. The counselors see the other consultants on a regular basis following a routine schedule.

The internist reviews all cases requiring medical services to assist the counselor in making his determination of the client's eligibility for the program. He studies the general medical report along with any other specialists' reports, the case history of the client, and consults with the counselor concerning the overall vocational potential in view of the medical prognosis. He might recommend further examinations, treatment or, in rare instances, even recommend that the case should be closed without further treatment if, in his judgment, the client would not benefit from the services that could be provided by the agency.

The psychiatric consultant spends much more time with the counselors than does the internist since a large number of school referrals are because of emotional problems. During the early stages of the Project the psychiatric consultant conducted weekly group meetings with the school counselors and the supervisors. The purpose of these meetings was to discuss mutual problems the counselors faced when dealing with reluctant and anxious parents who were threatened by the psychiatric problems of their children. The counselors were able to present case histories from the active caseload and receive a professional evaluation in making treatment plans, which would serve as a guide for the other counselors as well. Techniques of counseling were discussed from a professional standpoint and emphasis was placed on the limits of counseling in relation to psychiatric treatment. In these sessions the counselors learned through the experience of others, and the psychiatrist's evaluation, how specific problems should be approached. They also learned which approaches were effective and which ones were not. In many respects these were therapy sessions for the counselors, designed to reduce any anxieties they might have in working with their clients. The counselors who participated in these group sessions reported they found them both instructive and helpful. They were considered a part of in-service training and were an adjunct to the formal orientation period of a new counselor.

The counselors make frequent and effective use of the psychiatric consultant. Together they review cases, decide if extension of therapeutic treatment is feasible, change treatment procedure or, in certain cases, recommend further examinations such as neurological, speech assessment, etc. In some cases the consultant is used to advise the counselor on the proper referral physician. At times the consultant might recommend, for example, that a female therapist be used for a diagnostic evaluation or that the present treatment plan be abandoned and the client referred to Butler Hospital as a potential Day-Care patient.

The psychologist has worked closely with the DVR agency in setting up guidelines and standards for the type of reports requested from testers. He reviews cases with the counselors to decide authorization of evaluation services in projective testing, vocational listing, personality profiles, etc. He helps interpret the results of the testing and makes recommendations concerning further treatment. By correlating the psychological results with the psychiatric evaluation the psychologist creates the personality structure of the individual client, thus providing a teaching as well as consultative service. The psychologist, who is a member of the Rhode Island Psychological Association, acts as liaison between DVR and the psychologists. He interprets the agency policies and purposes to those working with the program.

The dental consultant is needed only on a limited basis, but he is available when there is a problem related to dentistry or oral surgery.

Through the coordination of expert consultants, reports and cases are more accurately interpreted and the best possible plan of treatment insured for each School Project client. A system has been established by the agency which is sufficiently flexible to deal with exceptional cases requiring unusual diagnostic services. By utilizing a variety of hospitals, agencies, physicians, psychiatrists, and psychologists in the community, the entire gamut of evaluative services has been made available to the clients referred to the School Project.

The DVR counselor is the crucial link in the functioning of the program. He brings together a wide variety of medical and paramedical specialists and services to meet the rehabilitative needs of the clients referred to the agency for help.

These clients represent all types of physical and emotional handicapping conditions which can be considered potential vocational handicaps. It is the responsibility of the counselor to provide whatever services will develop the client so he can successfully enter the labor force when he leaves school. A point to be emphasized here is that this Project was geared to people who are not yet in the labor force. As noted above, the emphasis here was to identify the disability at an early age and attempt to "prevent" the disability from developing into a vocational handicap.

CLIENTS SERVED

During the five year life of the Demonstration Project more than 5,000 teenagers were referred to the agency because of a wide variety of disabilities. Each disability was thought to be of such a serious nature that it either would be, or was likely to develop into, a handicap which would substantially limit the participation of the client in the labor force. Several hundred young men and women were referred to the Project each year. These data are shown in Table 2. Actually, during the last two years of the Project, approximately 1,000 such persons were referred annually. Thus as the program became more widely known the number of such referrals increased. The only exception to a general yearly increase in the number of referrals occurred between the second and third year of the program. This decline, however, was not due to a lack of interest in the program nor the absence of needs among perspective clients; rather, the decrease was in a large part due to a temporary decline in the funds available to the agency. Consequently many persons who might otherwise have been referred to the agency were denied the opportunity for such services. Later when funds became available the number of referrals again increased. The increases were particularly substantial during the last two years of the program.

The trend in new referrals is shown in Figure 1. The number of annual referrals increased from approximately 700 during the first three years of the Project to nearly 1,100 during the last year. Thus the number of referrals during the last year of the Demonstration Project exceeded the first year by more than 50 percent. It would seem evident that the widespread use of the Project demonstrates the need for such a facility. The ready acceptance of such a program not only by the school counselors but by the students and their parents further substantiates the need for such a Project.

TABLE 2.

TOTAL REFERRALS, ACCEPTANCES, AND CASELOAD BY YEARS

Year	New Ref. During Year	Referrals To Date	New Accept. During Year	Acceptances To Date	Caseload at End of Period
Prior to Beginning of School Project	620	983	363	363	983
1962-63	717	1700	357	720	1461
1963-64	624	2324	487	1207	1762
1964-65	717	3041	457	1664	1865
1965-66	971	4012	640	2304	2168
1966-67	1087	5099	786	3100	2426

Although the school guidance counselor is the one who makes the initial recommendation for referral, the client is not officially referred to the program until approval is obtained from the parents of the client. Experience has shown that in nearly all cases the parents approved the formal referral to the agency after the DVR counselor met with them and described the purpose of the Project and the type of services available to the client through the agency.

The number of new acceptances during each year is also shown in Figure 1, as well as in Table 2. In general the number of acceptances follows the same pattern as the number of referrals. That is, with only one exception (1964-1965), the ratio of acceptances to referrals remained rather constant as is shown by the slope of the trend line. The decline in acceptances lagged the decline in referrals. That is, while referrals declined during the second year of the Project in anticipation of a drop in funds available, the number of new acceptances declined during the next year when funds were again limited. However, after this temporary decline the number of acceptances increased sharply during the remaining years of the Demonstration Project. The high point in number of acceptances occurred during the last year when nearly 800 new clients were accepted for treatment. This was more than double the number of clients accepted during the first year of the program.

Figure 2 and Table 2 show the total number of referrals and acceptances during the life of the Project. Prior to the beginning of the Demonstration Project there had been 363 clients in this age group accepted for treatment. During the course of the next five years the total number of clients accepted increased to 3,100. This means then that about three out of every five persons referred to the Project throughout the period were accepted for treatment. Apparently the method developed here to work through the schools in order to identify clients with handicaps at an early age is very effective. It seems quite evident that the school guidance counselors can, through their contacts with the students, effectively identify those who have disabilities and are in need of professional help. The large number of referrals and the high acceptance rate clearly supports the need for such a program.

Since the program is designed to provide preventive as well as corrective services to a young adult population, it is expected that the clients that are accepted for treatment will continue as active cases over a long period of time--at least as long as they remain in school. Consequently the caseload of the agency increases in size each year as the number of clients being treated under the program accumulate over time. According to the data presented in both Table 2 and Figure 3, the number of active cases increased sharply during the first two years of the Project. During this period the active caseload nearly doubled. Only slight but consistent increases occurred during the last year of the Project period.

At the end of the Demonstration Project the agency was providing services for nearly 2,500 clients. At this time the School Project was at full strength with thirteen counselors and two supervisors. While there was considerable variation among counselors, the average counselor had a caseload of nearly 190 clients. This is a rough measure of the heavy caseload carried by each of the counselors. It should be noted further that half of the counselors had been with the agency for less than two years and one-fourth for only one year. No doubt the heavy caseload is more of a burden on those who are relatively new to the agency than for those who have been with the Project since its inception.

One of the perennial problems faced by the agency is the high turnover among counselors as well as among supervisors. During the five-year period of the Project seven of the ten original counselors left the program. All but one of the seven resigned from the agency. The one that remained with the agency was promoted to supervisor in the regular program; thus was lost to the School Project, and his cases had to be transferred to a different counselor. It is highly significant, as well as complimentary to the Project, that the quality of the original counselors was such that they would be offered better positions elsewhere. Counselors leaving the program did so to accept such positions as college guidance counselor and consultant to the Department of Education.

Both of the original supervisors on the Project were lost at the beginning of the fifth year of the program. The senior supervisor, who had been primarily responsible for setting up the Project, was lost through death, while the other supervisor accepted a position in college teaching. Two new supervisors were appointed to fill these positions. Both had been long time employees of the agency and both were, at the time of their appointment to this Project, supervisors in the regular program. Thus, while the special School Project was new to both of the supervisors, they were intimately familiar with the functioning of the agency. The agency also appointed fourteen additional counselors during the period of the Demonstration Project; five of whom left the agency before the Project had completed its fifth year. In Figure 4 is shown the tenure experience of each of the counselors associated with the Project throughout the period. When the program started there were only ten counselors, but this number had increased to twelve by the close of the Project. Altogether twenty-four counselors worked on the Project, however, twelve had left the agency by the end of the program.

The full impact of a high turnover among counselors is difficult to appraise and even more difficult to demonstrate. Certainly it would be safe to assume that a degree of efficiency would be lost because of the lack of familiarity with the long range development of the cases under the counselors' supervision. This is not, however, a dimension of the problem that lends itself to easy measurement, and no attempt is made to do so here. On a logical basis it would seem that the program loses some of its potential because of the turnover among counselors. Since the counselors tend to move up to more attractive positions it seems reasonable to conclude that the agency, because of its salary scale, cannot compete successfully with other alternatives available to persons with the qualifications possessed by the DVR counselors who have been appointed to the special School Project.

When the counselors who left the agency were interviewed concerning their resignations, the general consensus was that the low salary scale for counselors in the agency was not competitive with other opportunities available to men with their qualifications. While they found the counselor's job challenging, interesting, and rewarding, they found it necessary to move on to other positions in order to improve their incomes. Later in the report the crucial role of the counselor in the day-to-day activities of the Project will be explored, but at this point it is noted that the program functions most effectively when the client remains with the same counselor. For this reason a high turnover among counselors created problems of serious dimensions. Here too, this cannot be demonstrated empirically, but it is a frequent observation made by the DVR counselors, the school guidance directors, and the clients themselves.

FIGURE 1.

NUMBER OF NEW REFERRALS

AND ACCEPTANCES BY YEAR

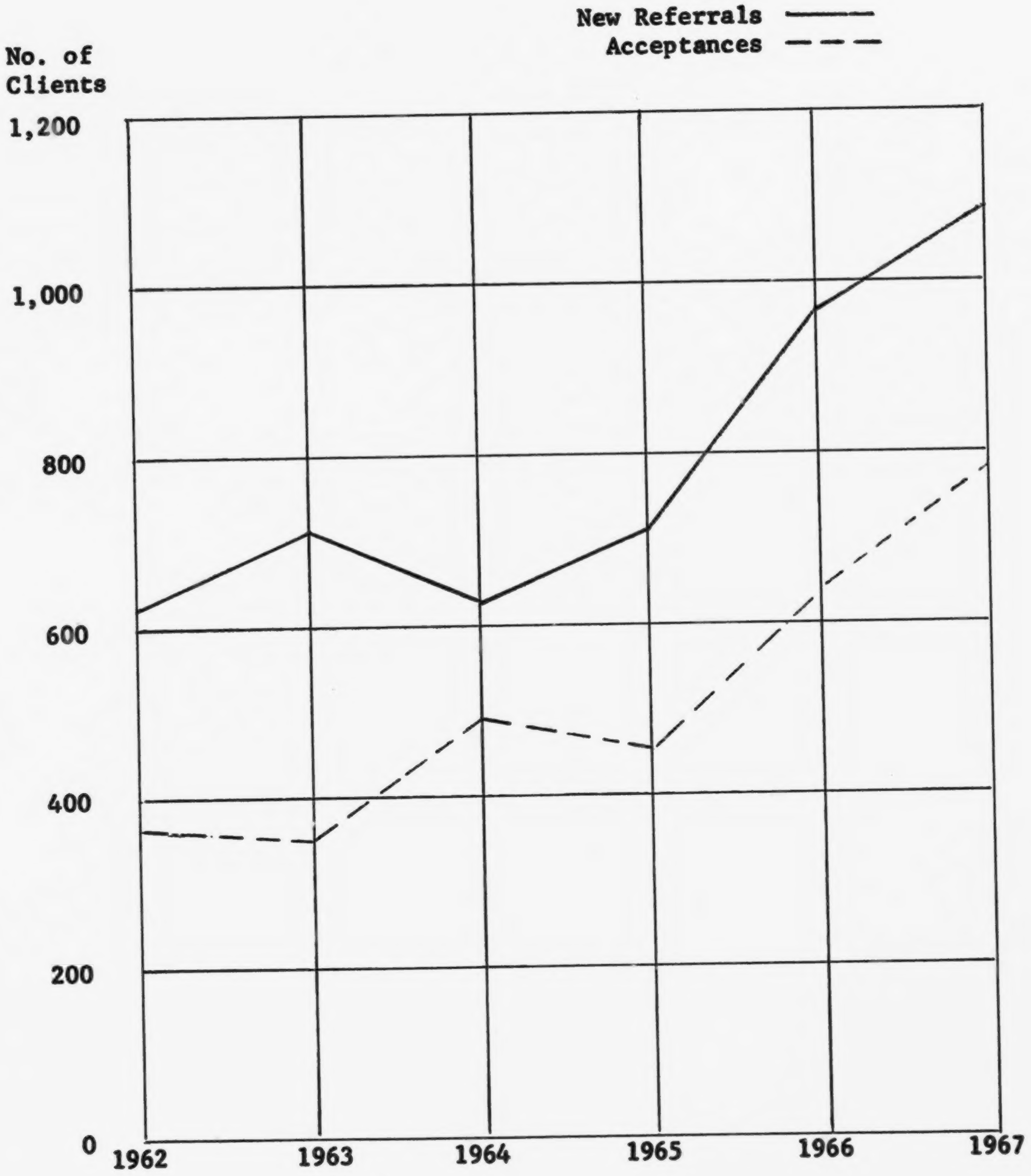

FIGURE 2.

TOTAL NUMBER OF REFERRALS
AND ACCEPTANCES BY YEAR

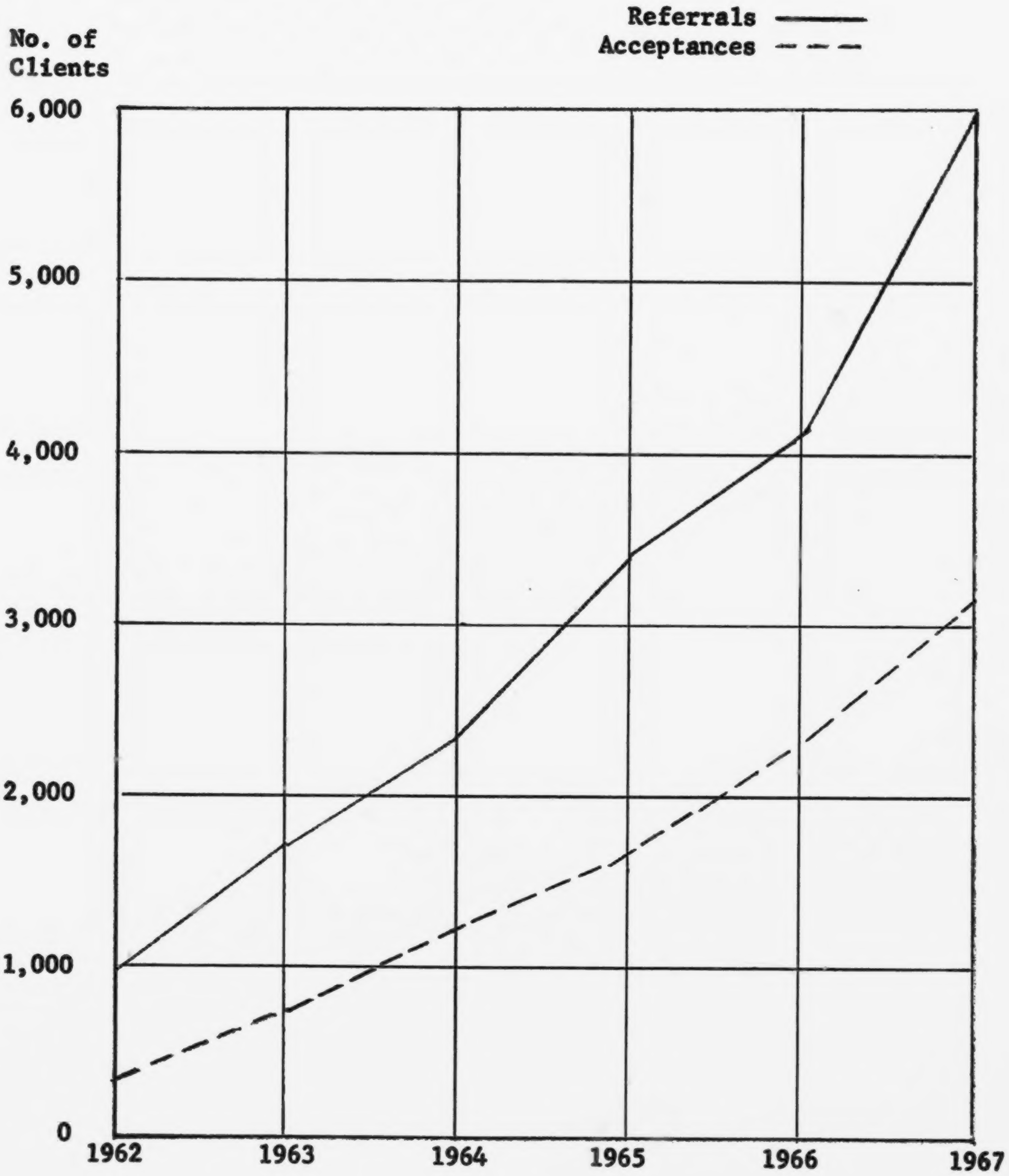

FIGURE 3.

ACTIVE CASELOAD AT END OF PERIOD

BY YEARS

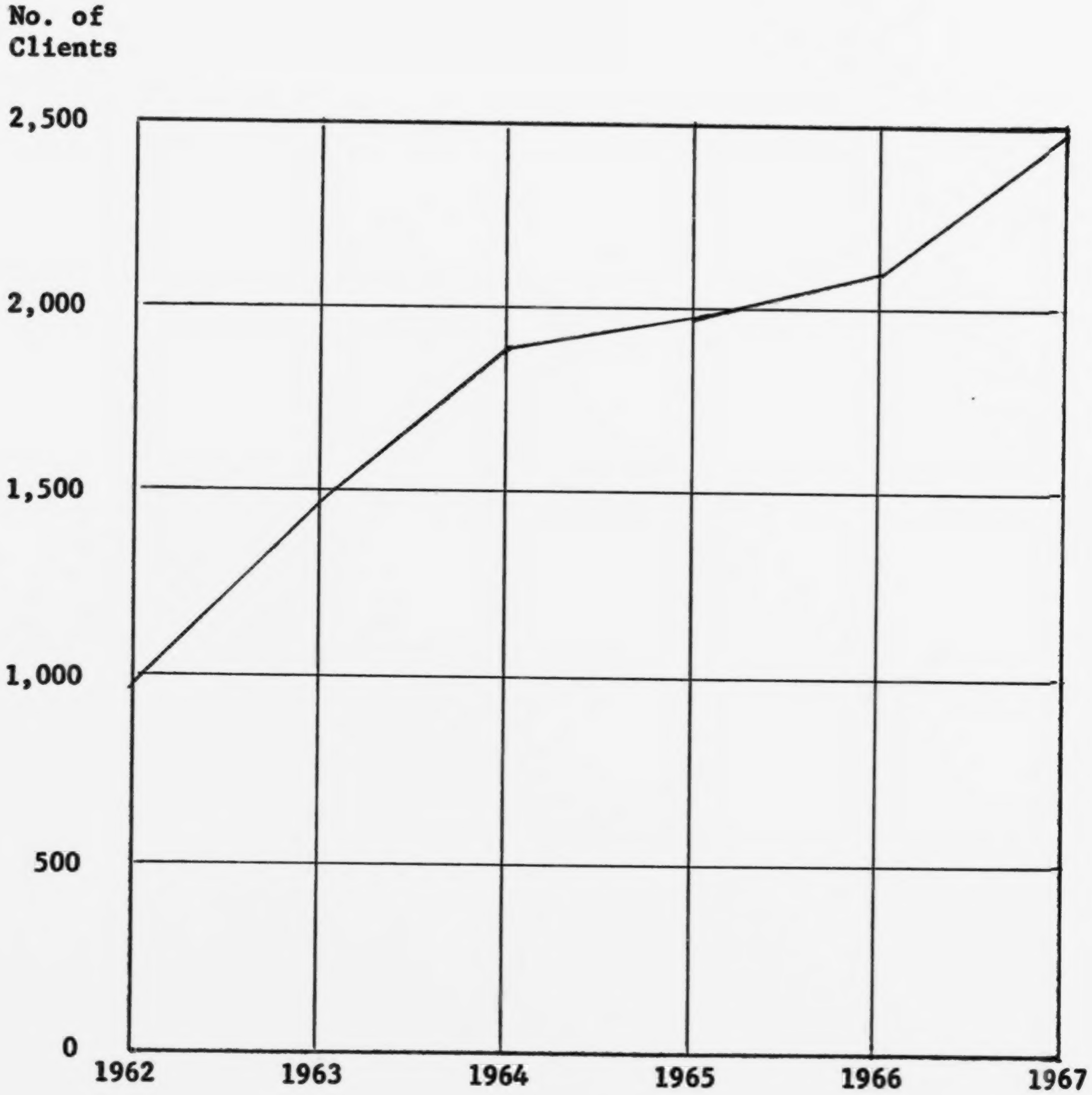

FIGURE 4.

LENGTH OF TIME COUNSELORS SERVED ON PROJECT
BY ORDER OF APPOINTMENT ON PROJECT

Counselors By Order of Appointment	1963		1964		1965		1966		1967		No. of Periods Employed
	Jan.	July	Jan.	July	Jan.	July	Jan.	July	Jan.	July	
1	X	X	X	X	X	X	X	X	X	X	10
2	X	X	X	X	X	X					6
3	X	X	X	X							4
4	X	X	X	X	X	X					6
5	X	X	X	X	X	X	X	X	X	X	10
6	X	X	X	X							4
7	X	X	X	X	X	X	X	X			8
8	X	X	X	X	X						5
9	X	X	X	X	X	X	X	X	X	X	10
10	X	X									2
11		X	X	X	X						4
12					X	X	X	X			4
13					X	X	X	X	X	X	6
14					X						1
15					X	X	X	X	X	X	6
16						X	X	X	X	X	5
17							X	X	X	X	4
18							X	X	X	X	4
19							X	X	X		3
20							X	X			2
21								X	X	X	3
22									X	X	2
23									X	X	2
24									X	X	2

POPULATION SERVED

This Demonstration Project was designed to serve the handicapped adolescent population in the schools of Rhode Island ages fourteen through twenty-one. All types of physically and emotionally handicapping conditions which may be considered as potential vocational handicaps are served. It was the purpose of the Project to demonstrate the effectiveness of this type of Vocational Rehabilitation program. This section of the report is primarily concerned with the type of population served.

At the time of this inventory the Division of Vocational Rehabilitation had nearly 5,000 clients on their active rolls. Of this number more than 1,800, or approximately 40 percent, were in the School Project. Among the latter more than 1,000 clients, or 55 percent, had been accepted for treatment. The other 45 percent were in the referred status category. These cases were being processed by the agency.

While the population reached by the School Project differed in many important respects from that served by the regular vocational program, there were only very minor differences in the sex and race composition of the populations in the two programs. Males accounted for approximately two out of every three clients served by the agency.

As shown in Table 3, the proportion of males was only slightly higher in the School Project than in the regular program. Since the inception of this Project we have observed a marked tendency for males to be referred much more frequently than females. However, since the latter had a higher acceptance rate, this suggests there was a tendency to refer males with fewer genuine problems than was the case for females. It may be that the predominance of males reflected a bias in the referral system which viewed the services of this agency as being primarily "vocational", thus applying especially to males expected to become the traditional "breadwinners" in the family. It may also be that females with similar problems were less of a problem in the school setting, thus their deficiencies were not considered significant to justify their referral for help from this agency. It may also be that the males were more disruptive in the day-to-day functioning of the school thereby becoming more evident to the school counselor. At any rate, the regular program of the agency effectively reached a higher proportion of the females than the School Project.

TABLE 3.

SEX OF CLIENT BY TYPE OF PROGRAM

Sex	School Project (1867 Clients)	Regular Program (3115 Clients)	Total (4982)
Male	67.3	64.1	65.3
Female	32.5	35.8	34.5
Not reported	0.2	0.1	0.1
Total Percent	100.0	100.0	100.0

Differences by type of program were also observed in respect to the social composition of the population served. While Negroes make up only 2.4 percent of the total state population, they accounted for more than five percent of the active clients in the regular program and 3.4 percent in the School Project. The reason for the higher proportion of Negroes in the regular program is likely to be found in the referral practices and not in the acceptance procedures since, as is pointed out later, Negroes when referred were accepted by the agency at an earlier date than whites. Although the social differences by type of program may be due only to chance factors, the differences are substantial. The higher proportion of Negroes in the regular program may be due to the large number of referrals from welfare agencies which are likely to come into contact disproportionately with this segment of the population. This was particularly the case among females. We find that Negroes accounted for 6.5 percent of the females referred under the regular program as compared with 4.5 percent of the males, as shown in Table 4.

TABLE 4.

RACE OF CLIENT BY SEX AND TYPE OF PROGRAM

Race	School Project			Regular Program		
	Male	Female	Total	Male	Female	Total
White	96.5	96.4	96.4	95.3	93.3	94.5
Negro	3.3	3.6	3.4	4.5	6.5	5.2
Other	0.2	- -	0.1	0.1	0.2	0.1
Not reported	0.1	- -	0.1	0.2	- -	0.2
Total Percent	100.0	100.0	100.0	100.0	100.0	100.0

Viewing these data from a different perspective we find that Negroes, in relationship to their proportion of the total population, were overrepresented in the School Project by some 40 percent. This ranges from 33 percent among males to 50 percent among females. However, in the regular program Negroes were even more overrepresented. Among males the active cases exceeded the average for the Negro population by some 88 percent and among females the overrepresentation exceeds 170 percent.

Turning our attention to the data presented in Table 5, we find that the School Project in particular was effectively reaching the population of the whole state. Only 27 percent of those in the School Project lived in the city of Providence. This is approximately equal to the proportion of the total population of the state that is found in the city. In the regular program nearly 40 percent of the clients were from the city. A further inspection of the place of residence of the active cases shows the School Project attracted a larger proportion of the clients from the more distant parts of the state than did the regular program. For example, while 30 percent of the school clients lived in the third and fourth ring removed from the city of Providence, we find that only 22 percent of the regular clients lived in these areas.

TABLE 5.

PLACE OF RESIDENCE OF CLIENT BY TYPE OF PROGRAM BY CURRENT STATUS

	School Project			Regular Program		
Residence	Referred	Accepted	Total	Referred	Accepted	Total
Providence	28.3	26.2	27.1	39.5	39.4	39.5
First Ring	36.8	34.5	35.4	33.3	32.2	32.7
Second Ring	7.6	7.9	7.8	4.0	5.8	5.1
Third Ring	20.7	22.7	21.8	14.4	14.5	14.4
Fourth Ring	6.7	8.7	7.8	8.8	8.1	8.4
Total Percent	100.0	100.0	100.0	100.0	100.0	100.0

It is worthy of note that in neither program was there a difference in the distribution of residence of the accepted cases as compared with the referred cases. This is particularly significant in that it clearly demonstrated that the agency effectively serves the population referred to it for their services, regardless of where they live in the state. Although the central office is located in the capital city, the services offered are distributed in the same way the cases are referred for assistance. This is a remarkable accomplishment for any state agency since one would expect the provision of services would vary according to the accessibility of the client served. This is not the case, however. Regardless of where people live when they are referred they have an equal chance to be helped by the agency.

The effectiveness of the methodology employed within the School Project is shown by the widespread residential distribution of the clients that are referred for treatment. The Project set up a system whereby counselors periodically visit schools throughout the state to offer services. They have successfully reached a segment of the population not ordinarily reached by a state service rendering agency. While the regular program drew their clients disproportionately from the city, the School Project reached a more widespread population. Although both programs are similar in their effective acceptance of referred cases, regardless of where they live, the School Project has been more successful in getting referrals from areas throughout the state.

The School Project reached a different kind of population than did the regular program of the agency. This is a significant factor in that it dramatically demonstrates how the objectives of the School Project differed from the traditional goals of a rehabilitation agency. The School Project is perceived as having been primarily a preventive program, while the regular program must necessarily focus on corrective measures. This difference in focus is evident in that the School Project was designed for young adults, most of whom are in the mid-teens. It is to identify problems at an early stage so corrective measures can be taken to prevent these problems from evolving into adult problems that would handicap the person in seeking a position in the labor force and, at that time, require corrective treatment. In short, the School Project was preventive rehabilitation long before the clients were to enter the labor force. Consequently the two programs reached a different type of population as is shown in Table 6, which is concerned with the primary source of support of the clients by type of program.

TABLE 6.

PRIMARY SOURCE OF SUPPORT OF CLIENT BY TYPE OF PROGRAM

Source of Support	School Project	Regular Program
Current Earnings	0.9	9.7
Family & Friends	88.2	34.9
Private Relief Agencies	- -	0.1
Public Assist. w/Fed. Funds	4.7	17.1
Public Assist. w/o Fed. Funds	0.3	8.8
Public Inst. - Tax Supported	3.0	2.2
Workmen's Compensation	- -	7.2
OASI Disability Benefits	- -	3.4
Other Disability	0.2	13.2
Not Reported	2.7	3.5
Total Percent	100.0	100.0

The most striking fact here is that more than nine out of ten of those accepted on the School Project were non-welfare cases. That is, the program catered to a population of young adults from families that were largely self-supporting. Less than eight percent of the clients came from families receiving some type of welfare assistance. By way of comparison, some 28 percent of the regular clients received their primary source of support from welfare funds. Only about four out of five were self-supporting, while one in four obtained their primary source of support through Workman's Compensation or some disability program. The latter account for only two cases out of more than 1,000 clients in the School Project. It is also noted that less than one percent of the clients in the School Project reported current earnings as their primary source of support, while ten percent in the regular program were in this category. Thus the School Project obviously catered to young adults who are still dependent on their families for support and few of these families are not self-supporting. The obvious purpose of the program was to treat the young adults at an early age so as to prepare them for positions in the labor force. In this sense it was clearly preventive.

The majority of cases covered by the Demonstration Project were referred through educational institutions. As is shown in Table 7, approximately two-thirds of the active cases were referred by this source. The only other sources to account for more than ten percent of the referrals were the welfare agencies throughout the state. Only in rare instances do we find self-referral or even referral from some interested individual, but these two sources combined account for nearly ten percent of the referrals. A small minority of the cases were referred either by physicians or a health agency.

TABLE 7.

SOURCE OF REFERRAL TO SCHOOL PROJECT
BY SEX AND RACE

	Male			Female		
Source of Referral	White	Negro	Total	White	Negro	Total
Total Clients	1,212	41	1,256*	585	22	607
Educational Institutions	66.2	58.5	65.9	64.4	36.4	63.4
Hospitals & Sanitoriums	2.1	- -	2.1	2.4	- -	2.3
Other Health Agencies	2.7	4.9	2.8	3.1	13.6	3.5
Physicians	7.6	2.4	7.4	8.0	- -	7.7
Welfare Agencies	9.7	31.7	10.5	10.4	36.4	11.4
Individual**	5.3	2.4	5.2	5.3	4.5	5.3
Self-Referred	3.5	- -	3.4	4.6	9.1	4.8
Other	2.6	- -	2.5	1.8	- -	1.7
Not reported	0.2	- -	0.2	- -	- -	- -
Total Percent	100.0	100.0	100.0	100.0	100.0	100.0

* Includes Not Reported as to race.
** Other than client.

By and large there were no marked differences in source of referral by sex. Both men and women were about proportionately referred by the same source. However, this was not the case when we compare the white and Negro clients. Negroes were more than three times as likely to have been referred by welfare agencies and less likely to have been referred by educational institutions. The race difference was particularly marked among females, but the same pattern of difference was also found among males. Thus, while 64 percent of the white females were referred by educational institutions, only 36 percent of the Negro females were referred by this source. The proportion referred by welfare agencies, however, increased from ten percent of the white females to 36 percent of the Negroes. A nearly comparable difference was observed among the males. Of particular interest here, also, is the higher proportion of Negro females who are self-referred.

When we examine the length of time between referral and acceptance as shown in Table 8, there are no differences by sex, but there are small differences by race.

TABLE 8.

LENGTH OF TIME FROM REFERRAL TO ACCEPTANCE
BY SEX AND RACE

Time	Total		
	Male	Female	Negro
1 month or less	14.5	14.0	23.4
2 - 3	22.4	26.5	20.0
4 - 6	23.9	21.0	26.6
7 - 12	20.5	20.1	16.7
13 months and over	18.6	18.4	13.4
Total Percent	100.0	100.0	100.0

While only 14 percent of the total referrals were accepted during the first month, the proportion increases to 23 percent among the Negro referrals. Thus, in actual practice, Negroes had an acceptance rate during the first month which was approximately 65 percent higher than for all of the referrals that had been accepted.

Viewed somewhat differently, while about 60 percent of the total active cases were accepted within six months after referral, some 70 percent of the Negroes were accepted within this time period. Thus it is evident that in processing the clients either the Negroes were given preferential treatment or their problems were more pressing, and it was readily evident that they merited acceptance. It may also be Negroes were readily accessible to the central office since they live near the center of the city, therefore, their referrals could be processed more readily. At any rate, it is evident that even though Negroes tend to be referred from a different source than whites, the processing of the referrals tends to favor the former group. There is, however, no indication of any deliberate effort on the part of the agency to make any distinction among their clients, regardless of type, as far as kind of treatment offered or the speed at which the client's referral will be processed. Apart from earlier acceptance, the Negro client received the same attention as the members of any other group.

It is also noted that, in general, two cases out of five had been accepted as an active case for treatment within three months from the time of referral. On the other hand, less than one case in five had not been accepted within a year from the referral date.

TABLE 9.

AGE AT TIME OF REFERRAL TO PROGRAM BY SEX

Age	Male	Female
Total Number*	1,256	607
14 years	26.2	21.4
15 "	24.5	24.9
16 "	20.6	22.1
17 "	14.2	16.5
18 "	7.2	6.1
19 "	2.7	2.6
20 "	1.4	1.6
21 "	0.7	0.8
22 " **	0.4	0.3
23 " ***	1.8	3.5
Total Percent	100.0	100.0

* In four cases the Sex was not reported.

** Includes clients 22 years and over who are in school.

*** Includes clients 22 years and over who are NOT in school.

That the School Project attracted a very young population is evident from the age distribution shown in Table 9. More than one-fourth of the males and one-fifth of the females were referred at either 14 or 15 years of age. Approximately one-third of the clients in the School Project were 16 or 17 years of age while less than 15 percent were 18 years of age or over at the time of referral. Thus it is abundantly clear this program catered predominantly to young teenage persons who had problems that were thought to be of a nature to hinder seriously the eventual adjustment of the young adult in a regular occupation in the community. The Project was based on the premise that by reaching its clients at a very young age more serious and more long-lasting problems can be prevented from developing.

TABLE.10.

EDUCATIONAL LEVEL AT TIME OF ACCEPTANCE BY SEX

Education	Male	Female
Total Number	697	343
6 or under	17.3	11.1
7 & 8	19.2	19.8
9	17.5	17.5
10	15.1	17.8
11	15.5	16.6
12	7.5	10.8
13 & up	2.2	2.0
Other & Not reported	5.7	4.4
Total Percent	100.0	100.0

The majority of the clients accepted for treatment under this program had not yet entered or were in their first year of high school. This varies only slightly by sex. These data are shown in Table 10. While 54 percent of the male clients were in the 9th grade or below at the time of acceptance for treatment, we find that 48 percent of the females were at this educational level. On the other end of the educational scale, only about two out of 100 accepted cases were at the college level. At the high school level, we find 38 percent of the males as compared with 45 percent of the females. The point to be emphasized here is that problem identification and treatment is occurring at an early stage of the educational process. By working directly with the schools through close contact by periodic visits by the counselors, problem cases were referred at a young age and in the early grades. These data further emphasize the preventive aspect of the Project.

The problems or major disabling conditions found among the accepted cases cover a wide range. There are also small differences by sex as is evident from the data presented in Table 11. Amputation or the absence of extremities are rare disabling conditions among these cases. However, orthopedic impairments account for a sizable number of the cases. This category, including all subtypes, accounted for the major disabling condition of 18 percent of the female cases and 14 percent of the male clients. Visual impairments were found among approximately five percent of the cases among both males and females. Females, however, were much more likely to have hearing impairments. They exceeded the males in all subcategories. Hearing impairments accounted for only five percent of the male, but 12 percent of the female disabling conditions.

Approximately one case in four that was accepted on the active rolls of the agency under the Project had their major disabling condition classified as either psychosis or psychoneurosis or as mental retardation or deficiency. It is noteworthy that another 25 percent of the males and 19 percent of the females were found in the personality, character, and behavior disorder category. Thus, for approximately half of the cases, the major problem seemed to be emotional or mental; a type of problem that likely can best be handled if treated in the early stages as was done under this Project.

Lastly, when we turn our attention to the origin of the disability of the clients in the School Project as compared with those in the regular program, we found significant differences as shown in Table 12.

TABLE 12.

ORIGIN OF DISABILITY BY TYPE OF PROGRAM

Origin of Disability	School Project	Regular Program
Disease	54.2	71.5
Congenital	35.0	8.3
Other Accident	9.6	7.9
Employment Accident (Comp.)	0.7	10.8
Not reported	0.4	1.5
Total Percent	100.0	100.0

More than seven cases out of ten in the regular program were in the

TABLE 11.

MAJOR DISABLING CONDITION BY SEX

Major Disabling Condition		Male		Female
Amputation or Absence of Extremity		1.1		0.6
Orthopedic Impairments		14.3		18.0
Upper Extremities	3.4		2.6	
Lower Extremities	4.9		7.0	
Both Extremities	4.7		7.5	
Other parts of body	1.3		0.9	
Visual Impairments		5.2		5.5
Hearing Impairments		5.0		11.9
Deaf - unable to talk clearly	1.4		3.5	
Deaf - able to talk	1.8		3.5	
Other	1.8		4.9	
Speech Impairments		3.9		3.5
Psychosis & Psychoneurosis		11.1		11.0
Mental Retardation or Deficiency		14.0		13.3
Cardiac Diseases		3.1		1.7
Epilepsy		3.0		3.8
Tuberculosis, Pulmonary		0.4		0.3
Disabling Conditions NEC		11.7		9.6
Personality, Character & Behavior Disorders		24.8		19.4
Not reported		2.3		1.4
Total Percent		100.0		100.0

disease category, but this accounts for only slightly more than half of the clients in the School Project. On the other hand, for 35 percent in the School Project the origin of their disability was classified as congenital, as compared with only eight percent of the clients in the regular program. Accidents, other than employment accidents, accounted for less than ten percent of the cases in both programs. The point of particular significance here is the high proportion of cases in the School Project in the congenital category.

To this point we have described the type of population served by the School Project as compared to the regular and traditional program of the agency. This comparison is important in that it focuses on how the agency performed a function where its services and know-how have been extended to a different segment of the population than in the past. Not only did the School Project reach the problem cases at a young age whereby preventive rehabilitation becomes the major focus, but in catering to these kinds of problems, the agency provided a vital service to families throughout the state that ordinarily would not be able to provide this rehabilitation service through their own resources. Perhaps even more important is the fact that in the absence of this Demonstration Project many of the parents would not even have known their children were suffering from problems demanding professional attention. The fact so many of the families willingly took advantage of the services of the agency is strong presumptive evidence that the Project has not only demonstrated the need for such services, but also it has demonstrated that families with children who have problems are eager and willing to obtain professional assistance in an attempt to overcome these problems.

Since the program was geared to a young population it remains to be seen whether or not the agency can effectively resolve these problems and prepare these young adults for productive positions in the community. Only a small proportion of the clients had finished school and entered the labor force at the close of the Demonstration Project. Some measure of the success of the program can be determined by an analysis of these cases. A majority of the clients are still on the active caseload of the agency. A full appraisal will not be possible until these cases finish school and enter the labor market. Before considering the closed cases our attention is focused on how the agency functions at the diagnostic level. This is one of the major functions of the agency. It is considered in detail in the next section.

DIAGNOSTIC SERVICES - ACTIVE CASES

The previous discussion has been primarily concerned with the type of population served by this Project. This section is more concerned with various aspects of the functioning of the program. The major focus will be concerned with an analysis of diagnostic services that were provided for the clients that were active cases at the time of the inventory.

Throughout the Demonstration Project the most frequent disability had been emotional disturbance. The next most frequent disabilities were orthopedic impairments and mental retardation or deficiency, which occurred with about equal frequency. These three disabilities combined accounted for approximately half of all the referrals in the Project. However, it should be stressed that while many referrals were seen initially because of orthopedic impairments, mental retardation, etc., often it was discovered even in these cases the major disabling condition was emotional disturbance.

This section of the report is limited to a descriptive discussion of the type of diagnostic services provided for the clients who were active cases during the fourth year of the School Project. This is intended to demonstrate the workings of the agency through a brief statistical account of the services rendered at the diagnostic level. Since the data apply to the cases that were open on the rolls or had been served at the time of the inventory of services, the clients were at various stages in the diagnostic-treatment program. Of the nearly 2,500 clients included in this analysis some 30 percent were at the "referred" stage. These cases were in the process of receiving diagnostic services as part of the regular procedure for working out a treatment program. Another 42 percent of the clients had been accepted for treatment in the program. That is, they had passed through the diagnostic stage and had been accepted by the agency. The remaining cases were closed. For purposes of this part of the report attention is focused only on the diagnostic services provided during the year. Later in the report we will describe the whole range of diagnostic and treatment services which were provided for the cases that were closed at the end of the Demonstration Project. The cases reported on in this section represent the regular distribution of clients by status that is usually handled by the agency at any particular point in time, thus it demonstrates the regular functioning of the agency as it proceeds toward its goal of rehabilitation.

The question of concern is: "What types of diagnostic service were provided for these clients?" Considering the cost factor first, we find the agency expended more than $50 per client active on their rolls during the year for either medical or psychological diagnostic services. The overall average costs, based on the total number of clients in the program, was approximately two dollars higher per client for medical than psychological services. However, this cost difference is misleading for it reverses and becomes much larger when we focus only on the client that received a specific diagnostic service. For example, as shown in Table 13, while only slightly more than half (51.9 percent) of the total costs were for medical diagnostic services, we found these services accounted for more than 70 percent of the authorizations. The average cost per authorization was less than $16. By way of contrast, while only 28 percent of the total diagnostic authorizations were for psychological services, the costs account for nearly half of the total expenditures. The average cost per authorization for psychological diagnostic services was nearly twice as high as for medical services, that is,

$37 compared with less than $16. Thus, to present average cost figures by including all of the clients in the computation is to give a completely false description of the relative expenditures for different diagnostic services, since psychological services are much more costly per authorization than medical services.

TABLE 13.

TYPE OF DIAGNOSTIC SERVICE BY COST AND AUTHORIZATION

Type	Costs	Percent Distribution	Authorization	Percent Distribution	Average Costs per Auth.
Total	$ 134,872	100.0	6,216	100.0	$ 21.69
Medical	69,977	51.9	4,460	71.8	15.70
Psychological	64,895	48.1	1,756	28.2	37.00

A point to be emphasized here is that services provided at this stage were not available in the schools, thus there was a real need for this type of program. When asked to appraise the function of the DVR program in the schools the school guidance counselors frequently stated that the schools would never be able to supply the type of services the agency provides. The usual comment was to the affect that the schools could not do without the program in many areas of service. As one counselor stated, "The School Project of the DVR provides counseling and services the schools could not possibly provide." Perhaps the same issue was more clearly stated by the guidance counselor in one of the suburban schools who reported, "The DVR Project fits into the school's program very well. It offers a different kind of service. Counseling at the school pertains to school problems, while the DVR counseling pertains to life problems." Or as another stated, "The resources and know-how of the DVR go beyond the limits of the school." The same theme was expressed by still another counselor thusly, "The agency can do something for the youngster that the school cannot do. The guidance counselor can advise and counsel but can do nothing concrete; rehabilitation can provide services." In other words, the agency not only recommends, but also carries out the recommendations.

The specific type of medical diagnostic services provided for the clients by the Project is shown in Table 14. The range of services needed and the frequency of use further demonstrates the need for such services. Here, too, we found the distribution of authorizations is quite different from the distribution of costs. For example, while general medical examinations accounted for 44 percent of the total authorizations, they absorbed only 22 percent of the total expenditures for medical diagnostic services. On the other hand, less than 10 percent of the authorizations were for neurological services, but these accounted for nearly 14 percent of the expenditures. The most significant point here is the large proportion of the diagnostic dollar that goes for psychiatric services. Of the total number of medical authorizations only 21 percent were for psychiatric services, but these accounted for 45 percent of the total expenditures. Thus it is abundantly clear that in this particular Project a high disproportionate amount of DVR funds were devoted to psychiatric services. Here, too, we found that to attempt to describe the work of the agency in terms of authorizations only would misrepresent the emphasis of the program. While a general medical examination was authorized twice as frequently as psychiatric services, it cost only half as much.

TABLE 14.

DISTRIBUTION OF MEDICAL DIAGNOSTIC SERVICES BY AUTHORIZATIONS AND COSTS BY TYPE OF SERVICE

Type of Medical Service	Authorizations		Costs	
	Number	Percent	Dollars	Percent
Total	4460	100.0	$69,977	100.0
General Medical	1981	44.4	15,463	22.1
Neurological	443	9.9	9,478	13.5
Orthopedic	237	5.3	1,675	2.4
Psychiatric	953	21.4	31,610	45.2
Hearing	233	5.2	1,944	2.8
Vision	201	4.5	1,787	2.5
Speech	79	1.8	1,113	1.6
Dermatology	28	0.6	290	0.4
Dental	28	0.6	186	0.3
Cardiac	56	1.3	670	1.0
Internal Organs	23	0.5	432	0.6
Allergy	26	0.6	348	0.5
Hospitalization	27	0.6	2,553	3.6
All others	145	3.3	2,428	3.5

Still another way of viewing medical diagnostic services is in terms of the proportion of cases receiving each type of service and the average cost per person. These data are presented in Table 15. Of the total number of cases studied, nearly eight out of ten had a general medical as a part of the diagnostic evaluation. This was done at an average cost of less than nine dollars per client receiving this service. The next most frequently used diagnostic service was psychiatric. Nearly one-third of the clients (31 percent) received psychiatric service at an average cost of nearly $50. Neurological service was the third most frequently authorized. This was used by nearly 14 percent of the clients. The average cost per client was around $37.

Orthopedic, hearing and vision services were used with about equal frequency by around seven percent of the clients. The average costs for each type of service was less than $15. As is evident from the data presented in Table 15, the other medical services were used to a lesser degree, but the range of such services were needed by a substantial number of the clients referred to the agency.

TABLE 15.

PROPORTION OF CLIENTS RECEIVING MEDICAL DIAGNOSTIC SERVICES BY TYPE AND AVERAGE COSTS PER CLIENT

Type of Medical Service	Percent of Clients Receiving Service	Average Cost of Service
General Medical*	77.8	$ 8.71
Neurological	13.5	37.31
Orthopedic	7.5	15.95
Psychiatric	31.3	49.39
Hearing	6.9	14.09
Vision	6.9	12.16
Speech	3.1	19.19
Dermatology	0.7	16.11
Dental	0.8	10.33
Cardiac	1.8	30.45
Internal Organs	0.8	27.00
Allergy	0.8	18.32
Hospitalization	1.0	159.56
All others	4.7	26.39

* The cases that did not have a general medical report in them were referred by either physicians or hospitals, with complete medical data accompanying the referral; consequently, it was felt unnecessary to authorize a general medical.

At the diagnostic stage about 40 percent of the active clients had received at least one of the services classified under psychological. However, as shown in Table 16, projective testing was one of the most frequently used services and was one of the most costly for the agency. We find that slightly more than one person in four received this service at an average cost of $52. Altogether projective tests accounted for 40 percent of the expenditures for psychological diagnostic services. Since individual I.Q. tests were administered automatically in a projective test battery, the number of I.Q. tests was relatively the same as the number of projective tests indicated in Table 16. Occasionally I.Q. tests were authorized singly, therefore they are listed separately in the Table. Vocational tests were administered to nine percent of the clients and used up 12 percent of the expenditures. In addition to this 12 percent, a number of clients had been tested by D.E.S. or other agencies.

TABLE 16.

PROPORTION RECEIVING PSYCHOLOGICAL DIAGNOSTIC SERVICES, AVERAGE COSTS AND DISTRIBUTION OF EXPENDITURES BY TYPE OF SERVICE

Type of Service	Use of Service Yes	No	No Data	Average Costs Per Client Rec. Service	Percent Distribution of Expenditure
Total	40.2	59.0	0.8	$ - -	100.0
Projective Tests	26.2	72.9	0.9	51.88	40.3
I. Q. Tests	26.3	72.5	1.2	22.19	0.5
Vocational Tests	9.0	89.5	1.5	40.07	12.3
Scholastic Tests	4.1	94.4	1.5	38.70	4.4
Workshops	4.5	93.9	1.6	250.50	42.5

Scholastic tests and workshops were authorized with approximately equal frequency to less than five percent of the clients. Cost-wise, however, workshops average some $250 per client, whereas scholastic tests amount to less than $40 per client. From the point of view of the total budget expenditures, workshops were more costly than any of the other services. This service alone accounts for more than two-fifths of the total expenditures for psychological diagnostic service. While it was authorized very infrequently, it is costly. Thus, if we look only at the number of clients served, this is no index of the proportion of the resources of the agency that was devoted to this service. Less than five percent of the clients received this service but they used up 43 percent of the total expenditures devoted to psychological diagnostic services. Actually, when viewed in respect to total expenditures for all diagnostic services, including medical, expenditures for workshops accounted for 20 percent.

In summary, we find that at the diagnostic level the number of authorizations for medical tests were much more frequent than psychological examinations. However, as far as the financial resources of the School Project are concerned, expenditures were nearly equally divided between medical (including psychiatric) and the services classified as psychological. Most authorizations fell into four categories; that is, general medical, neurological, psychiatric, and projective tests. The four services that accounted for most of the funds expended were psychiatric, workshops, projective tests, and general medicals in that order.

Of these services the general medical was authorized most frequently and workshops the least. The main point to be emphasized is the services which were most frequently used in diagnosis, and the ones that proved to be the most costly, were the types of services the schools could not provide for themselves. While the provision of these services accounted for a large part of the work of the DVR in the School Project, the present description of the services provided demonstrates not only the magnitude of the function of the agency, but points to the crucial role of the School Project in relationship to the schools.

The importance of the School Project is best summed up by the guidance counselor who stated, "We couldn't get along without the Project." Those data serve to emphasize that a great deal of effort went into each case that was referred to the agency even before it was accepted for treatment. By focusing on the diagnostic services only, it becomes evident that "Closed" cases are not an adequate index of how the agency functioned or of the services it provided. By the very nature of the Project much effort was expended that was essential to the day-to-day activities of the agency, the results of which will never show up as a "success" case for the records.

It should be continually emphasized even in these cases, the School Project, in catering to these problems, provided a vital service to families throughout the state. Many of these families would have been unable to provide these services through their own resources and certainly the help needed was beyond the facilities or capabilities of the schools. Perhaps what is even more important is that in the absence of this Demonstration Project many of the parents would not have known the extent to which their children had problems and were in need of professional help. The fact that so many children throughout the state have made use of the services of the agency is sufficient evidence that a need for this type of aid exists.

SPECIAL TREATMENT FACILITIES AVAILABLE

Most of the services needed for treatment of the clients on the School Project were purchased in the community. However, if the need is such that it requires facilities not readily available in the community, authorization was given to obtain the service elsewhere. This was frequently the case for highly specialized needs and for training, particularly at the college level.

A. The College Program

Among the closed cases we find that 143 clients had attended college or technical school under this program. However, the clients attended forty-five separate institutions throughout the country. While most of the clients attended schools in Rhode Island or in neighboring New England states, there were no restrictions placed on the choice of a school if it appeared that it would best meet the individual needs of the client. The contribution made by DVR for such training, as part of the treatment process, varied according to the financial needs of the family. A yardstick for measuring financial need in making grants for college and other training for young persons with disabilities is computed in a manner similar to the Princeton Schedule; e.g., the entire educational costs of a youngster of a family with gross income of less than $4,000 would be underwritten. A family of five with income of $8,000 would be expected to participate in costs to the extent of $630 a year. Regardless of income no youngster receives less than $400 a year from DVR while in a training program.

That this aspect of the program met with marked success is suggested by the low proportion of clients that had dropped out after entering college or a technical school. Of the 143 clients that attended such schools only twenty-two dropped out. This is a loss rate of approximately 15 percent. It is of more than incidental interest to note that not a single client that attended a school outside of the state dropped out. The drop-out rates were particularly high only among the following three schools within the state: Johnson and Wales, Rhode Island Junior College and the University of Rhode Island. On the other hand, the retention rate among institutions in the state was particularly high at both Providence College and Rhode Island College. These two schools enrolled thirteen and seventeen clients respectively. Why these differences exist is not readily apparent.

B. Butler Hospital: A Day-Care Program

For ten years the regular program of the Division of Vocational Rehabilitation has been referring clients to Butler Hospital, a private mental hospital which operates a well-organized Day-Care Program appropriate for adolescents. Many of the School Project clients were referred to private psychiatrists for short-term therapy. However, it soon became apparent that some clients required more intensive services in order to become vocationally independent. As the number of emotionally disturbed youngsters on the School Project increased, it became necessary to have a variety of referral sources available for treatment. The Butler Day-Care Program became the most widely used service for psychiatric cases requiring more than routine treatment.

Clients referred to the Day-Care Program were more severely disturbed, requiring a wide gamut of services rather than just therapeutic support. Many required a complete change from their environment. Some, unable to cope with school, were considering dropping out; others had already left temporarily and were having difficulty in their home environment. Many were spending empty, listless days, unable to find work or anything constructive to do. A few clients under great pressure in school needed a brief respite in order to gather new strength. The Day-Care Program was five days a week although some youngsters arranged to remain in school two or three days a week and attended the hospital alternate days.

The Butler Day-Care center is a rehabilitative psychiatric treatment center providing a coordinated program to meet the educational, creative, recreational, medical and therapeutic needs of emotionally disturbed adolescents. Based on a milieu therapy philosophy, it offered the School Project client the freedom of choice in the selection of activities, with the benefit of guidance and supervision by well-trained personnel. A psychiatrist was director of the program; he worked closely with the clients providing individual psychotherapy for some and group therapy for others, according to their needs. All patients on the program benefited from the interpersonal relationships developed between the staff and the clients.

The program was structured to provide a wide variety of activities for adolescents and young adults. A certified teacher on the staff conducted her classroom each morning. In an informal atmosphere students studied the subjects they were taking at their own local high schools, trying to keep up with the school curriculum. Some clients pursued independent study; one female client for example, spent many hours learning the Greek language. She had entered the program despondent and disinterested, but through her interest developed a new outlook on life. She began to read everything available on Ancient Greece and gradually began to communicate with the other patients, as well as the hospital personnel. Some clients learned how to write business letters in order to be able to apply for jobs, and some learned to fill in employment applications. Art and music, as well as the usual academic subjects, were explored. To many of the youngsters this was their first acceptable school experience.

In the area of creative activities the Day-Care center provided many diverse opportunities. A complete sewing room offered female clients the chance to learn how to design and sew their own clothes, learn simple dressmaking, and practice knitting and embroidering skills. Weaving looms were available to the clients who made fabric linens and gift items. A well equipped ceramics workshop, an oil painting studio, a metals and crafts shop provided adolescents the chance to develop artistic skills. There is a woodworking department that is useful as an occuptional therapy device, as well as a means for learning professional carpentry. In this shop smaller items such as bookends, trays, and stools are made. However, it is also possible to construct chairs and tables, small chests, and to refinish furniture. A printing shop with printing presses and all the necessary equipment makes it possible for someone to study printing and engraving. In the shop clients have printed hospital signs, menus, and Christmas greeting cards. A kitchen in the Day-Care center has all the facilities to prepare young ladies for homemaking or cooking. Youngsters learn menu planning, preparation of foods, and baking. On several occasions they have cooked complete dinners for the clients and Day-Care personnel.

The adolescents had the opportunity to use the recreational facilities on the hospital's spacious grounds. In a fully modern gymnasium basketball, volleyball, badminton, and bowling are held on different days. During the proper season tennis and baseball are organized activities. Since many of the clients are withdrawn and passive, participation on the athletic field is at first very limited, but experience has shown that after several days of watching and slowly making friends with other young people with similar problems, the clients gradually release their inhibitions and join in all the planned activities.

A weekly staff meeting of the Day-Care staff and any DVR counselors who have clients on the program was instructive. Clients were discussed in relation to their progress, their interaction with others, and their attitudes toward the staff. As the clients improved suggestions were often made by the psychiatrist or social worker regarding their vocational goals, A DVR coordinator was a regular member of the staff meeting and he interpreted the results to any counselors unable to attend.

By means of a wide range of activities this program has been created to help adolescents with emotional difficulties find their own identity in an environment without pressures. The Day-Care program has been a successful half-way house in helping youngsters adjust to the community while maintaining a contact with the professional personnel of the hospital. It has been most effective in providing a place where young people can go rather than face hospitalization on an in-patient basis. In some cases the latter treatment not only would have provided even more of a financial strain on the family, but would have further isolated the client. If many of these adolescents had been subjected to a psychiatric hospital, they would have withdrawn even more. Thus the Day-Care program, used as it has been by adolescents on the School Project, has proven to be a most important means in the prevention of institutionalization on a long-term basis.

C. Community Workshops

The Community Workshops program was designed to help clients with limited mental ability. When youngsters attending the regular schools have reached their full potential, within the limits of their ability, they are referred to the Division of Vocational Rehabilitation for a diagnostic evaluation and referred to the Community Workshops program which determines their "work potential" and trains them for employment. The facilities and services used in the evaluation and training in the Community Workshops program are paid for in part from DVR funds. While the local school system is expected to provide transportation for getting the client to the workshop, under some circumstances the agency will also pay transportation costs. The amount of time required for an evaluation to the Workshops may range from three months to a full year. At the end of the evaluation the client is either judged as one who is capable only of sheltered work or one who has the potential to function successfully in private employment.

Some of the clients have returned to regular schools after the workshop experience when the staff felt the client would benefit from further training. Others who were not yet mature enough for work, but who were too retarded to participate in regular classroom work, have been placed in ungraded classrooms. Still others have been trained to enter limited private employment, usually in factories, if they have the minimum requisite ability; whereas those who are too retarded for such work are placed in sheltered workshops where they can do simple operations. The Cranston Chapter for Retarded Children has developed a workshop which contracts certain jobs, requiring only very simple tasks, with local factories. It is in such places that the more retarded client can find a job that can be handled within the limits of his ability.

In conjunction with this type of program there is another project that attempts to train female clients for routine tasks in Rhode Island Hospital. For example, retarded female clients receive twelve weeks of training in household tasks by Rhode Island Hospital. This training is supported in part by funds paid by the DVR agency. That is, during the training period the DVR pays half of the client's wages while the hospital pays the other half. Upon completion of the training period the clients are hired by the hospital for a variety of work such as housekeeping, tray girls, or as helpers in the kitchen.

What the program has accomplished is evident from a review of the cases served during the one year period from July 1, 1965 to June 30, 1966. The Community Workshops program served 115 clients during this period--sixty-seven males and forty-eight females. While the facilities and services of the program are generally available to all schools in the state, a large majority of the clients come from the City of Providence and the nearby cities and towns due, no doubt, to its location. It would be quite inaccessible to those who live in the out-state area. Since this was an exploratory project a central location had merits; however, the reason for its location is that the drive leading to its establishment came from the Cranston Chapter for Retarded Children. Of the clients served by the Community Workshops program nearly one-fifth had been school dropouts from regular classes and another 29 percent had dropped out from special classes in which they had been placed because of their disabilities. About half of the clients had been referred directly from the schools through the DVR counselor. Experience has shown that when referrals are made while the client is still in school the results are much better than if the client has already dropped out of school. This observation further supports the position that preventive rehabilitation is most likely to succeed if the client can be identified and treated before he has had too many negative experiences resulting from his disability.

The limited mental ability of the clients referred to the workshops is evident from distribution of I.Q. scores shown in Table 17.

TABLE 17.

DISTRIBUTION OF I.Q. SCORES

I.Q. Scores	Percent
Under 70	19
70 to 80	28
80 to 90	30
90 and Over	23
Total	100

Nearly one-fifth of the referrals had I.Q. scores below 70. More than half had scores within the range of 70 to 90. Less than one-fourth of the clients had I.Q. scores of 90 or higher. For the whole group the reading ability was evaluated at the sixth grade level, while arithmetic was only at the fifth grade level This takes on added significance when it is noted that at least two-thirds of the clients were eighteen years of age or older. The median age of the clients on the program was eighteen and one-half years.

While emotional problems were frequently cited as a disability, these were accompanied in most cases by marked mental retardation. In Table 18 below, we find the type of disabilities that were listed among the clients that were referred. More than one-fifth of the clients were mentally retarded but had no previous history of having been treated for emotional problems. A slightly smaller proportion of the clients had physical disabilities. Here, too, there does not seem to be any previous history of treatment for emotional problems. In all of the other cases the mental or physical disability was in combination with emotional disabilities and the remainder presented mental and physical disabilities simultaneously. In this classification the client was considered to have an emotional problem only if he had received prior psychiatric treatment or hospitalization. Most of the mentally retarded were immature and over-protected. Thus it is quite clear that the clients referred to this program were burdened with both serious and complex disabilities and yet many were successfully treated in the Workshops program.

TABLE 18.

PERCENT DISTRIBUTION BY TYPE OF DISABILITY

Disability	Percent
Mentally Retarded	22
Physical Disability	18
Mentally Retarded & Physical Disability	16
Mentally Retarded & Emotional Disability	9
Physical & Emotional Disability	7
Emotional Disability	11
Mentally Retarded, Physical & Emotional Disabilities	17
Total	100

For a variety of reasons not all clients took full advantage of the program of evaluation and training that was offered. Shortly after they entered the program nearly one client out of five (18 percent) dropped out. A slightly higher proportion (19 percent) were terminated by the agency early in the program because after evaluation they either did not show any vocational potential or they were so seriously disturbed that they could not adjust to the program at that time. Thus 37 percent of the clients were terminated shortly after they entered the program. On the other hand, 63 percent of those that participated in the program were successfully placed. About five percent were able to return to school, 28 percent were placed as sheltered workers and 30 percent were placed in jobs in private industry. Given the type of disabilities outlined above this is a very commendable record. A majority of those who participated in the program were placed in jobs that would permit them to lead productive and meaningful lives.

The program was not able to successfully overcome the limiting influences of a low I.Q. The jobs in outside industry were obtained disproportionately by those with the higher I.Q. scores. For example, only five percent with I.Q. scores below 70 were able to obtain outside employment. The proportion increased to 20 percent among those with scores between 70 and 80, and increased to 26 percent with I.Q.'s between 80 and 90. However, as noted, 30 percent of the clients obtain such positions which means that the rate was much higher for those with the high I.Q. scores. Most of the clients with limited I.Q. scores remained on as sheltered workers.

This program caters only to a small segment of the clients referred to the agency on the School Project, but it has demonstrated that it can effectively work with those who have serious mental disabilities.

D. Meeting Street School: An Inconclusive Innovation

One of the very promising innovations in preventive rehabilitation, that is, group therapy not only for the client but for their parents as well, was introduced at the Meeting Street School. This program was set up for those disabled clients who were not emotionally disturbed to the extent of warranting psychiatric treatment, and who also did not meet the basic criteria for Community Workshops, but were in need of some type of maturation program as a pre-vocational conditioning experience. Although it proved to be a very effective method of treatment it was discontinued because it could serve only a small population and was thus excessively expensive on a per-client basis and very time consuming for the professional staff. If the resources were available this method of treatment appears to hold a great deal of promise for certain type cases. For this reason a brief description of the program should be included in a report on the results of the School Project. The fact that it was discontinued should not detract from its merits.

After careful screening, a select group of clients from the School Project, as well as their parents, met separately on a regularly scheduled basis for group therapy. The weekly sessions continued for thirteen weeks. In these sessions a group of parents under the supervision of a psychologist, and their children under the supervision of a psychiatric social worker, held discussions on the problems faced by the disabled clients and how the families and the clients might attempt to cope with their problems. In these sessions the clients were urged to talk to their peers about their disabilities and the kinds of problems they were experiencing. The parents, meeting in separate groups, were also encouraged to discuss their child's problems from their point of view, and how they felt they should try to help their child. Through a free exchange of views concerning such problems and a discussion of possible alternatives available for coping with such problems, plus the knowledge that others also had comparable difficulties, it was the goal of the program to make the clients and the parents more understanding of the issues at stake.

In setting up this program it was recognized that the parents also had problems of adjustment. Through these group therapy sessions it was expected they would be better prepared and equipped to work out more satisfactory relationships with their children.

While the feelings on the part of the professional staff that participated in these sessions were generally favorable, the program was discontinued because of the uncertainty of the outcome. By the very nature of the sessions there where no objective measures whereby the success could be documented. However, among the small group that did participate at least two of the parents reported they "had been helped tremendously." The sessions gave them a much better insight into their problems and they were able to change the methods they had used in handling their child. They had learned new methods and as a result treated their child differently. When the sessions were discontinued the parents felt that they missed them.

There was some unsystematic and impressionistic evidence that several of the clients had learned to verbalize through this experience. But still, given the ambiguity of such a program, "personal adjustment training" which was the goal of the program is difficult to justify. As already noted, it is both costly and time consuming and can service only a small group. Since resources were limited it was decided this program should not have a priority, consequently it was discontinued. The results of such a program remained inconclusive.

E. Boystown Ranch Island Camp (Known as Dr. Rossi's Camp)

The camp was founded in 1962 by Dr. Matthew Rossi for the purpose of providing a wholesome camping experience for emotionally disturbed boys from six to twelve years of age. In a short time youngsters with other handicaps were admitted. It was found that many emotional problems run hand in hand with physical defects. Youngsters served by the camp had a wide range of both physical and mental disabilities. As the camp grew there was the need to expand the staff. The idea was conceived to utilize DVR clients who had problems themselves and would benefit from the camping experience, but who would be capable of carrying out the duties and obligations of a "counselor-in-training." The youngsters were carefully screened by the DVR psychiatric consultant and were also interviewed by Dr. Rossi. The initial fee to DVR for the vocational training experience was $900 a summer, but this was raised to $1,100 for the ten-week camping period.

For the past few summers about fifteen boys and girls from the School Project have attended this camp as counselors-in-training. It is considered a pre-vocational aptitude screening by means of which the youngsters are given personal adjustment training. In an environment of harmony, stability and organized work and play, youngsters with emotionally disturbed backgrounds and inadequate homes are given the opportunity to grow and develop. At the camp emphasis is placed on the interaction of people and interpersonal-relationships between the client and others. In this environment it is possible to observe a youngster function in many diverse areas. He is given the responsibility of working with the younger campers along with the regular trained camp personnel. He is also given supervision by the camp director and head counselor who oversees the program. All of the campers, as well as those in the counselor-in-training program, are encouraged to remain for the complete summer. The counselors-in-training receive a weekly allowance from the camp of about $5.00, and if the client has performed in an outstanding manner, he receives a greater remuneration. Almost all of the clients who had participated in this program made a successful adjustment at the camp. Even more important, many of them found regular employment after the camping experience. Some of the young men joined the military service; some joined youth programs as aides or activity leaders; one or two went to Ladd School where they were employed as counselors; some returned to the camp the following summer as regular counselors; and some, who were high school drop-outs, returned to school where they successfully completed their education.

The camp provides the counselor-in-training clients a wide range of sports activities such as swimming, baseball, boating and horseback riding. However, much of their day is devoted to vocational training through a wide range of activities offered. The camp, which is located on Prudence Island, has 800 acres and thus is a natural setting for farming. Experience is gained in dairy farming, garden farming, animal breeding and raising, production of feed for farm animals, and poultry products. A vegetable garden was maintained all summer which produced fresh vegetables for the kitchen. Some male clients enjoyed ground maintenance and were responsible for cutting the grass, watering and beautifying the campsite. Construction was a popular activity and developed carpentry skills among some of the young men. They painted the bunks, made repairs, developed terraces, built stone walls, and completed a dormitory building.

The camp has been able to purchase a good supply of heavy equipment which the boys have used to build a tennis court, maintain roads, erect docks, and clear land. A driver training course was available for those youngsters anxious to receive their driver's license. For the young female clients there was training in domestic work such as ironing, setting the table, and planning and preparing meals. There was clerical experience offered in the form of typing, filing, general office procedure, and filling out applications for jobs. In conjunction with the vocational training there was a program directed at creative and intellectual pursuits. An advanced college student who has had special education training was available mornings to help students in any area of study. Remedial reading was available for those with reading problems. There were complete arts and crafts facilities where the campers could paint, make mosiacs, sculpture, etc.

In the area of recreational activities, each evening the camp had a special program designed to meet the needs and interests of the campers. There were relays and games, cookouts, campfires, informal dances and the usual gamut of activities which appeal to teenagers.

The camp was non-profit, and many of the youngsters were sponsored by civic groups and agencies. The camp has been successful because it has had a skilled and dedicated staff, excellent facilities, a varied program, and a therapeutic atmosphere where youngsters and young people with disabilities can escape the pressures of society and develop their own skills and insights. The majority of campers have returned to their homes healthier and happier after a summer in this environment. It has also afforded relief to the families of many of those youngsters who were involved in strife and problems. When the families were reunited they were able to cope with each other better, had better understanding and more patience. Lasting friendships were made, and many of the counselors-in-training continued a contact with the camp director throughout the year. For many of the campers this program provided an opportunity where they could develop a meaningful relationship with others. It was also their first opportunity to live together compatibly with a group of people their own age.

EVALUATION OF PROGRAM - SURVEY MATERIAL

In this section our attention will be focused on some of the factors that contribute to the successful functioning of a Project of this type. That is, a Project which was directed largely to the teenage population and attempted to identify persons with handicaps predominantly through referrals from the schools of the state. The present discussion is based on a schedule of questions which were administered through personal interviews with school guidance counselors throughout the state. The analysis is limited only to the high school population. This has limitations since it tends to miss the younger age groups which constituted a large proportion of total referrals. For example, about one-fifth of the referrals in this Project were adolescents under fifteen years of age. Many, if not most, of these would have been in the junior high schools at the time of referral. It is evident from past experience that this is a crucial age in the demand for the type of service provided under this program. We realize the shortcomings of limiting our analysis to the high schools, but feel that the findings justify their presentation. The data were gathered by an experienced interviewer who had earlier participated in a number of special independent studies sponsored by the regular DVR program.

One of the focuses of the following discussion concerns the very general question of how the Project functions and what are some of the factors that account for the effective utilization of the resources of the agency. The present report will attempt to comment briefly on some of the things we have learned about carrying out such a Project. Since the Project worked predominately through the guidance counselors, an attempt was made to assess the views the guidance counselors had of the agency and how it functions. As part of this assessment a trained and experienced interviewer, who does not work for either the schools or the Rehabilitation agency, arranged personal interviews with the head counselor in each of the high schools of the state. The present summary is based on reports from thirty-two of the state's thirty-nine public high schools. A point to be noted here is that only infrequent referrals have been received from the parochial schools in the state. It would seem that the lack of referrals from the parochial schools is due largely to the general lack of qualified guidance counselors or organized guidance structures in such schools. At least, this was one of the explanations offered in an interview concerning the DVR program by one of the top administrative officials in the Diocese of Providence. Our appraisal of the Project would certainly suggest a need to develop some effective way of reaching the children in the parochial schools. Although referrals did increase, they never did reach the level found in the public schools. Mention is made of this point to emphasize that there is still an unmet need in the state which will require further expansion of services.

As already noted, the interviews with the guidance counselors represented an attempt to find out how the schools viewed the agency and also to determine some of the factors that made for an effective program. An analysis of the survey data makes it abundantly clear that the DVR program was viewed favorably throughout the state. Of the thirty-one schools only one viewed the Project negatively, but a careful reading of the interview suggests that even here the services of the agency were considered necessary and were wanted, however, the Project failed to materialize because of the counselor. He proved to be irregular in his visits, lax in the handling of cases, and "promised everything, but did nothing." No doubt the most significant and persistent point throughout the interviews is that the functioning of the

Project is almost entirely dependent on the quality of the DVR counselor. While most of the DVR counselors did an excellent job, there were some who did not. Regarding the latter, the most common complaints expressed by the guidance counselors in the schools concerned the lack of regularity in their visits. The point was made over and over again that it was absolutely necessary for the DVR counselor to be consistent and regular in his visits to the school. Unfortunately this practice was found to be lacking in some cases, but only among a small minority of the counselors. Most counselors were dependable and followed a regular schedule so the guidance counselor would know when to expect him and could work with his students and their parents accordingly.

The importance of this was made evident by the interviewer when she was asked to summarize her views as to what made the School Project successful. In response to this question she wrote, "The one outstanding constant factor is the caliber of the counselor. In those schools where the DVR counselor was considered reliable, consistent, and dependable, the reaction of the school was positive toward the agency even if some problems existed. However, in those schools where the counselor did not visit on a regular basis, and where the counselor had the reputation of breaking appointments, the image is negative ...... there appears to be the need for more rigid programming and routine schedules by the counselors because the schools applauding the program were those who had steady counselors." This general opinion is clearly evident when one reads the interviews.

The highly significant role of the DVR counselor cannot be overemphasized, for on his performance depends the whole program. Another closely related factor was the extent to which the DVR counselor and the guidance counselor related successfully to each other. That is, any given counselor may work much more effectively in one school than in another. This was usually found to be due to differences in quality of the interpersonal relationships between the individual personalities of the DVR counselors and the guidance counselors. This would lead us to recommend that the supervisor should not only observe the overall quality of the DVR counselor himself, but also how successfully he related to the individual guidance counselors in the different schools that he visits. In those cases where compatibility is lacking a reassignment should occur. Statistical support for this is presented in Table 19, and will be discussed more fully below. No attempt is to be made here to do a statistical analysis of the interview data, however, some of the most frequently mentioned strengths and weaknesses of the Project will be reported and points worthy of note will be illustrated by some of the views expressed by the school guidance counselor.

The general procedure for introducing the program to the schools was for the supervisor with the counselor, or on rare occasions one of the counselors alone, to visit the school and meet with the school guidance counselors and usually the school nurse. The Demonstration Project was explained as being available to any student fourteen years of age or over who might have a physical, emotional, or psychological handicap. The schools were told that when they referred a prospective client to the DVR counselor he would interview the parents first to explain the program to them before interviewing the student.

The DVR was prepared to provide diagnostic examinations and follow-up treatment, training, and ultimately placement, when indicated. For the most part this procedure worked very effectively, however, problems in understanding the program tended to occur with shifts in personnel. Consequently, with the passing of time, considerable confusion developed as to the specific function of the agency. For example, we found some lack of understanding in a few of the schools in terms of the emphasis of the program. Some schools tended to see the DVR program as being primarily concerned with emotional problems, whereas others thought it was predominantly interested in physical handicaps. Also, some schools felt that the DVR counselor should actually counsel while others felt this was the function of the guidance counselor only and the DVR should serve only as a coordinating agency. The point here is that there was some confusion as to just what to expect from the agency. This lack of a clear understanding was not due to a failure to adequately explain the Project to the schools, but developed over a period of time due to a breakdown in communications whenever there were personnel changes among either the school or DVR counselors. When there was a turnover the details and specifics of the original introduction to the schools, regardless of its clarity, were not properly passed on to the next person. One of the frequent complaints about the Project was that there was a great deal of turnover among the DVR counselors. It should be noted, however, there was an equal, if not greater, turnover among guidance counselors.

The above problem could be alleviated in part by (1) returning to the school to reintroduce the program whenever there are personnel changes which might disrupt the smooth functioning of the program and/or (2) prepare a written pamphlet which fully describes how the agency functions in relationship to the schools and the types of services provided under the program. This pamphlet could be distributed to each of the schools and when there was a change in guidance counselors the DVR counselor could recommend that he examine the pamphlet to familiarize himself with the details of the program of the agency. This would likely be more effective than to depend on a verbal description. Also, if any questions should come up when the DVR counselor was not available, the guidance counselor could refer to the pamphlet. In some cases it may also be advisable to have pamphlets that the guidance counselors could distribute to the parents of a student that was to be referred to the agency. The parents would then come to the interview with the DVR counselor with a better knowledge of what the program had to offer.

The program tends to be viewed very favorably among the guidance counselors. They tend to see the agency as being able to provide services that are needed but beyond the facilities of the school. They feel that the program has been very effective and has provided many services to people who could never afford such services. It was not unusual for the schools to report that "the program is excellent," "the services of this agency are outstanding." One guidance counselor stated it thusly, "The DVR program has helped to make each child important by providing services that the schools are completely unable to provide." Almost without exception when the program is praised, its success is attributed to the counselor. The comment from one of the schools illustrates this: "The Project is excellent but this is definitely due to the present counselor who is a 'rare' individual." Still another school guidance counselor reports, "The success of the Project depends on the DVR counselor."

Some notion of how the better counselors are viewed by the schools is illustrated further by such comments as: "Mr. ____ was excellent. He went above and beyond the call of duty and was truly interested in all of the youngsters and their parents. He had an unusual way with people. He had great personal concern for the youngsters. I felt it, the teachers felt it, and the youngsters themselves knew he was deeply interested in their problems. They knew that he was sincere and the boys and girls trusted what he had to offer. He makes a great contribution. This school could not possibly get along without Mr. ____, the counselor, or the rehabilitation program. No counselor has ever given this school the outstanding services we are now receiving. ... The counselor is 'fabulous' ... 'exceptional' ... he is extremely well liked ... nothing is impossible or difficult for him and he is completely dedicated ... he does everything for the school ... we use him constantly and are never disappointed ... He works with the underachievers, the disturbed youngsters, and the physically handicapped ... He works with whole families and is even better than a social worker ... he is great ..." (This same school reported that not much had been done in the program until Mr. ____ arrived and then everything changed for the better. Incidentally, this same high praise was confirmed by the other schools covered by this counselor.)

Not all of the counselors were equally praised. Again, whenever the agency was not viewed favorably, the point of criticism was directed at the counselor and not at the agency or the services offered. The following comments, which were mentioned infrequently, are in sharp contrast to those already noted: "Often the counselors are mechanical and not really interested in what is going on. He is supposed to counsel students but rather thinks of himself as an amateur psychiatrist--spends hours with one case and ignores others. The present counselor is very dependable but the last one was lax and unreliable and not very good at counseling."

The one inescapable conclusion is that no matter how good the program--regardless of the funds or resources available, or the services that can be provided, the Project will work only to the extent that the DVR counselor is competent. Competence here encompasses a number of dimensions, not the least of which is empathy and interest. When the counselor performs badly the program falters. This is further illustrated by one of the guidance counselors who stated, "Up until Mr. ____ came we would hardly refer anyone because we were completely dissatisfied. Some of the counselors were very inadequate. We had no satisfaction for years because of poor follow-through and very poor DVR counselors. There has been much improvement in recent years. The program will function only when a competent counselor carries out the program." In this case when the counselor was changed the use of the services of the DVR increased.

One of the frequent criticisms of the program was the high turnover among the counselors. One school reported that the program of the DVR was outstanding, but that the counselor turnover was a problem. Still other schools claimed the DVR tended "to lose its better counselors. They can't keep good counselors, too many changes. When someone becomes oriented they tend to lose him. There have been four counselors in four years--this is a disadvantage to the youngsters." Obviously, this is a real problem as far as the continuity of the program is concerned, but how to resolve the issue is not readily apparent during a period of abundant opportunities for people with experience in this field. In addition, the agency has an In-Service Training Program which provides courses for counselors leading toward their Master's degree, thus, because of their experience and academic backgrounds, many attractive openings present themselves. Perhaps the negative consequences of turnover could be partially reduced by making available to the schools the type of pamphlet mentioned above which would describe the program and how the schools should work through the DVR counselor. The seriousness of turnover cannot be underestimated, however, for we have repeatedly found that the success of the program rests largely with the quality of the counselor. Clearly a high turnover damages the program. The present report merely states the problem. A solution is not readily apparent except that more competitive salaries would effectively decrease the amount of turnover. When counselors leave the Project it is invariably for a promotion or a higher salary elsewhere. This issue will be considered in more detail later.

Many of the guidance counselors expressed the opinion that the age limitation for the program should be reduced. There seems to be a rather widespread opinion that many youngsters could use and would be able to benefit from the program at a much younger age. Many feel the program should be extended under fourteen years of age when many of the problems are first developing. One of the guidance counselors stated the issue thusly, "I only wish they would accept clients at an earlier age level and would go into the grammar schools. The more you define a problem at an earlier age, the better able you are to service it." Another school counselor commented, "The biggest block is the age limit--a great number of problems begin before age fourteen and they should be referred earlier."

In response to the general question of how the DVR program fits in with the schools, the most common response was that the agency provided services which the schools were not able to provide. The typical response was "the schools would never be able to supply the services that the agency does." That the program is considered crucial to the schools is illustrated by one guidance counselor who stated, "Several of the youngsters would have been unable to go on without this help." Many of the guidance counselors expressed the opinion, "We couldn't get along without the agency." They feel it is a vital part of their counseling and guidance program. It is a substantial extension of their work and the need is vital.

Some of the guidance counselors feel the full potential of the agency is not being realized. This issue was expressed by one guidance counselor in this way, "I feel that when a youngster has received psychological testing or has had a psychiatric evaluation, the school authorities should know the results so they can better understand the nature of the youngster's problem." Still another felt he would like to have more clinical reports because he would like to know the dynamics of each case and how to interpret the youngster's problem to the people in the schools. A very similar opinion was expressed in this way, "I would like the test results with interpretations--would like recommendations so the schools would know how to work with the youngsters." In some cases the DVR was criticized because it didn't give the schools any directions as to how they could work into the rehabilitative picture. In short, many of the schools want to be told what they can do to be of help. Most guidance counselors felt that the program would be more effective if there was more and better communication between the schools and the agency, particularly when the client was under treatment.

Perhaps it is because of this interest that many complained about not receiving written reports on the progress of the cases that they had referred. This was almost a universal comment. There was general agreement, however, that if a DVR counselor was asked about a particular case he would give a full and complete oral report on what was being done. Nonetheless, some of the guidance counselors felt there was a real need for the schools to receive periodic and systematic written reports on all of the cases referred. The general theme throughout the interviews was that the schools really don't know enough about what the agency accomplishes with the clients that are referred. Some felt that if they were properly informed and the needs of the youngster told to them, the schools could help the child more in terms of his problems and his adjustment. Perhaps this type of complaint is best summed up by one of the guidance counselors who reported, "There is very little written material about what youngsters are on the program and what is being done for them." There seems to be general agreement that the schools would like to know more about what the agency is doing for each person referred.

Some of the DVR counselors do provide annual reports to the schools in which they incorporate the names of the youngsters served and the type of service provided. However, as a general policy the agency discourages the indiscriminate transmittal of confidential medical or psychiatric reports. Certainly, from an objective point of view, such a policy is fully justified on both ethical and professional grounds. Also, the agency feels that such reports to the schools may be harmful since most of the guidance counselors are not adequately trained to effectively handle emotional cases.

Perhaps some type of systematic reporting back to the schools would be worth the effort. A less burdensome approach may be for someone from DVR to meet occasionally with the teachers and guidance people in the school to discuss some of the cases referred from that school and explain what is being done for the youngster. At least this would demonstrate how the agency handles particular types of cases and the guidance counselors would have a better understanding of what to expect when a client is referred to the agency.

COUNSELOR RATINGS

We have already demonstrated from the interview data the crucial role of the DVR counselor in the functioning of the program. However, the significance of this point is even more dramatically evident from a statistical analysis of the use of the program in relationship to the quality of the counselor. Each of the DVR counselors was rated by an outside observer who was thoroughly familiar with the qualities of each of the counselors. This was done on a four point scale from excellent to poor. This was a subjective judgment but the person doing the ratings did not know how the ratings would be used in our analysis, thus, the variables considered here are independent of the ratings. These data are shown in Table 19.

TABLE 19.

SIZE AND PERCENT DISTRIBUTION OF HIGH SCHOOL POPULATION SERVED
AND USE OF DVR PROGRAM BY RATING OF DVR COUNSELOR

Rating of Counselor	H.S. Population		DVR Clients		Percent Over or Under Use	Percent Pop. in Program
	Number	Percent	Number	Percent		
Total	37,305*	100.0	988	100.0	- -	2.65
Excellent	18,957	50.8	574	58.1	+15.9	3.03
Good	9,493	25.5	250	25.3	- 0.1	2.63
Fair-Poor	8,855	23.7	164	16.7	-29.5	1.85

* Limited to 31 High Schools.

First of all, we found that half of the school population was covered by counselors who were rated "excellent." The remaining school population was covered about equally by "good" counselors and those rated as "fair or poor." The crucial role of the counselor in respect to the use made of the program becomes evident when we focus on the number and percent of cases on the program by quality of counselor. For example, while excellent counselors covered only half of the school population, they accounted for 58 percent of the cases. On the other hand, the "fair and poor" counselors accounted for only 17 percent of the cases, even though they covered 24 percent of the eligible population. The excellent counselors exceeded their share of the caseload by 16 percent, while the "fair-poor" counselors fall short of their share by 30 percent. These are marked differences.

Viewed from a different perspective we find that the proportion of the high school population in the DVR program varied directly by the rating of the counselor. Although the absolute percentage point difference does not appear to be large since only a very small proportion of the total eligible population is in the program, the relative proportions differed markedly. For example, while only 1.85 percent of the population is in the program in the schools covered by the "fair-poor" counselors, the proportion increases as the rating of the counselor increases and reached a high of 3.03 among the counselors rated as excellent.

The significance of these differences becomes even more evident when they are expressed as percentage differences. When this is done we find that the proportion of the population on the Project is 42 percent higher among the "good" counselors than among those rated as "fair-poor." The latter are exceeded by the "excellent" counselors by 64 percent.

As shown in Table 20, there was a direct relationship between the quality of the counselor and size of school served, but the differences in the relative proportion of the population reached is not a function only of size. For example, we find that while the average size of the school served by the "excellent" counselors (1723) is double the size of the school served by the "fair-poor" counselors (885), the average number of cases is three times as high among the excellent counselors--that is, 52 cases versus only 16 cases. No matter how we view the data we return to the inescapable conclusion, as already noted, that the functioning of the Project depends largely on the quality of the DVR counselor.

TABLE 20.

NUMBER AND PERCENT OF HIGH SCHOOL, AVERAGE SIZE OF SCHOOL AND AVERAGE CASES PER SCHOOL BY QUALITY OF DVR COUNSELOR

Quality of Counselor	High Schools		Average Size of School	Average No. of Clients per School
	Number	Percent		
Excellent	11	35.4	1,723	52.2
Good	10	32.3	949	25.0
Fair-Poor	10	32.3	885	16.4

The relationship between the DVR counselor and the guidance counselor is of almost equal importance. The point we wish to emphasize here is that the program functions best when the DVR counselor is of high quality and relates successfully to the guidance counselor. Although these two conditions tend to go together, there are exceptions, and when a high quality counselor is not able to relate successfully to the personality of the school guidance counselor, use of the program drops off. The two functions are interdependent and the program works most effectively when the persons in each capacity are compatible. Data to support this is shown in Table 21.

Half of the high school population in the state was covered by a DVR and school guidance counselor relationship that is rated as being excellent. This population accounted for 61 percent of the clients on the DVR program. On the other hand, 27 percent of the school population was served by a relationship which is rated as "fair-poor," and from this population the agency received only 18 percent of their cases. Stated somewhat differently, in the schools where the relationship between the DVR and school guidance counselor is excellent, use of the agency exceeded the relative proportion of the population served by some 21 percent. On the other hand, in the schools where the relationship is rated as "fair-poor" use of the program falls short of the expected by 31 percent. That is, they should have 27 percent of the cases, but contribute only 18 percent.

TABLE 21.

SIZE AND PERCENT DISTRIBUTION OF HIGH SCHOOL POPULATION SERVED AND USE OF DVR PROJECT BY RATING OF SCHOOL GUIDANCE-DVR COUNSELOR RELATIONSHIP

Relationship Rating--DVR-School Guid.	H.S. Population		DVR Clients		Percent Over or Under Use	Percent Pop. in Program
	Number	Percent	Number	Percent		
Total	37,305*	100.0	988	100.0	- -	2.6
Excellent	18,802	50.4	602	60.9	+20.8	3.2
Good	8,568	23.0	204	20.6	-10.4	2.4
Fair-Poor	9,935	26.6	182	18.4	-30.8	1.8

* Limited to 31 High Schools

The same relative difference is noted in respect to the proportion of population served by the agency. In the schools where the relationship is "excellent" 3.2 percent of the population is served by the agency but this proportion drops to only 1.8 percent when the relationship is rated "fair-poor." In short, the effective use of the Project depends not only on the quality of the DVR counselor, but on the quality of the relationship with the guidance counselor. If either are of a low quality, use of the Project declines.

A SAMPLE OF PSYCHOLOGICAL CASES

It has already been noted that most of the clients on the School Project had been referred because of psychological problems. For this reason we have selected out a special sample of cases from this category. From the file of active cases some ninety-one clients were selected on a random basis to permit a more detailed examination of their records. The following discussion is based on a careful examination of the ninety-one cases.

The sample selected was quite typical of the total active cases in terms of the sex breakdown, that is about two-thirds of the clients with psychological problems were male. Although the sample is small it seems to be quite representative of the total population, at least as far as the sex distribution is concerned. The age and sex composition of the sample is shown in Table 22. There seems to be little difference in age at time of referral between males and females with a third of the cases being referred at the earliest age when the agency will accept cases, that is, fourteen years of age. At least half or more of the cases were referred under sixteen years of age. While there was a slight tendency for the females to be referred at a slightly younger age than the males, this is reflected only among those that were referred after having reached their eighteenth birthday. Again the distribution here in terms of the age at referral tends to follow the general pattern observed for the total population served in the School Project. Most referrals were made when the client was either fourteen or fifteen years of age. This was held rather constant throughout the life of the Demonstration Project.

TABLE 22.

AGE AT TIME OF REFERRAL BY SEX

Age	Females		Males		Total	
	Number	Percent	Number	Percent	Number	Percent
14	11	32.4	18	31.6	29	31.9
15	9	26.5	11	19.3	20	22.0
16	5	14.7	12	21.0	17	18.7
17	7	20.6	10	17.5	17	18.7
18 Plus	2	5.9	6	10.6	8	8.8
Totals	34	100.0	57	100.0	91	100.0

When we examined the economic status of the clients we found that only a very small proportion, that is, less than ten percent are supported by any one of the public programs, such as Public Assistance, A. D. C. or O. A. S. I. These data are shown in Table 23. Less than five percent of the clients come from families with incomes of less than fifty dollars a week. Actually, even when we include those on public programs, only about one-fourth of the clients come from families with incomes below seventy dollars a week. On the other hand, nearly half of the clients come from families with weekly incomes of ninety dollars. Thus it is evident that the Project was reaching families in the upper income categories. At least 25 percent of the clients have incomes in excess of $110 per week. This then further illustrates that the School Project was reaching a segment of the population that is not ordinarily served by the Division of Vocational Rehabilitation.

TABLE 23.

ECONOMIC STATUS OF FAMILY

Economic Status	Number	Percent
Public Programs*	9	9.9
Under $50	4	4.4
$50-70	13	14.3
70-90	15	16.5
90-110	21	23.1
110-130	13	14.3
130 Plus	9	9.9
No Data	7	7.7
Totals	91	100.0

* State Ward, Public Assistance, ADC, or OASI

We now turn to an examination of some of the background characteristics of the sample population. It becomes evident that many of the clients came from homes where emotional problems were rather commonplace. This is evident from the data shown in Table 24, where we find that more than half of the clients came from families where at least one of the parents was classified as unstable and in need of help by the counselor.

TABLE 24.

FAMILY ENVIRONMENT OF CLIENTS

Family Environment	Number	Percent
One or both Parents Unstable (Either need or already under treatment)	48	52.7
Clients receive no Emotional Support from Parents (Family conflict or rejection)	24	26.4
Parents Try or at least Want to Help	19	20.9
Totals	91	100.0

The need for parental help was reported for forty-eight out of the ninety-one clients being studied here. For another twenty-four clients it was indicated that they could not depend on any support from their parents. This was reported as frequently for females as for males. In only about one case out of five did the counselor report that the parents were in a position where they would try to help, or at least they wanted to help the client. Thus it is evident that the clients in this disability category came from families that have problems. It is indeed striking that in more than one-half of the families either the mother or father and, in some cases, both the mother and father were either in need of psychiatric help or were already under treatment. In nine cases at least one of the parents was already under treatment and in nearly forty other families psychiatric help was needed.

These data indicate that perhaps a fruitful way to proceed in treating clients with problems of this type would be to focus on the whole family rather than just on the client himself. This becomes even more evident when we examine the home environment more closely, as we have done in the following, Table 25.

TABLE 25.

FREQUENCY OF HOME ENVIRONMENT PROBLEMS

Home Environment Problem	Number	Percent
Excessive Drinking	17	25.4
Harsh Destructive Punishment	4	6.0
Turmoil in Home (Parents do not get along-- Poor relationship with sibling)	31	46.3
Rejected--Abandoned	8	11.9
Other	7	10.5
Totals	67	100.0
Broken Homes by Type		
Divorce	15	45.5
Desertion	10	30.3
Death of Parent	8	24.2
Totals	33	100.0

Among the ninety-one clients in the sample we found sixty-seven rather serious problems in the home environment. These ranged from excessive drinking to constant turmoil in the home. The most frequent problem mentioned seemed to be a general turmoil in the homes which means either that the parents didn't get along with one another or the client had a poor relationship with one or more of his parents or his siblings. This type of home environment was reported by thirty-one of the clients. In seventeen other cases excessive drinking was reported as one of the problems in the home environment of the client. Excessive drinking accounted for about 25 percent of the problems mentioned, whereas, turmoil in the home accounted for about 46 percent of the problems reported. In eight cases the client was either rejected in the home or had been abandoned and in another four cases the client had experienced harsh and destructive punishment in the home.

It was readily evident that many of the clients came from a very unsatisfactory home environment. Given these conditions it is little wonder that children of this age would be suffering from emotional disturbances. Slightly more than one-third of the clients came from broken homes. The most frequent cause was due to divorce. This accounts for nearly half of the broken homes, whereas desertion accounted for about 30 percent and death of one of the parents was the cause of the remaining 25 percent. Thus it is evident that the home environment of many of the clients was less than satisfactory. No doubt the unfavorable home environment contributed, in a large part, to the type of behavioral problems we found among the clients in this sample.

Among the ninety-one cases some fifty-two behavioral problems were reported. Nearly half of the behavioral problems fall into two general categories as shown in Table 26.

TABLE 26.

FREQUENCY OF BEHAVIORAL PROBLEMS BY TYPE OF PROBLEM

Type of Problem	Number	Percent
Behavioral Problems:		
Lack of Friends--Unable to get along with people	13	25.0
Impulsive--Destructive behavior	13	25.0
Stealing--Police Trouble--Narcotic	7	13.5
Fantasies--delusions	5	9.6
Sexual Molested Children	7	13.5
Homosexuality	3	5.8
Other	4	7.7
Total	52	100.0
School Problems:		
Poor Student--Poor Grades	48	43.6
Failed Grades	23	20.9
Dropped out or Expelled	15	13.6
Discipline Problems	12	10.9
Excessive Absences	3	2.7
Other	6	5.5
None	3	2.7
Total	110*	100.0

* More than one problem listed for some clients.

For about one-fourth of the clients that had behavioral problems it was reported that they were unable to get along with people, that is, they lacked friends. Apparently they did not have the ability to interact successfully with others. Consequently they tended to live in isolation. This no doubt further aggravated their emotional disturbances. An equal number of clients had been characterized as being impulsive and destructive in their behavior. Thus the inability to maintain friendship ties with others and impulsive destructive behavior accounted for half of the behavioral problems reported. Other problems that occurred rather frequently involved such things as stealing, trouble with the police, playing around with narcotics, and sexually molesting younger children. Together these account for a third of the behavioral problems.

A small proportion of the clients had engaged in homosexual activities.

Not only were the clients characterized by a rather high frequency of behavioral problems, but a large number of problems related to the school were also noted. More than half of the clients were either rated as being poor students generally, or that they were getting poor grades although they were capable of doing much better work. More than one-fifth of the clients (23 out of the 91 clients) had failed at least one grade. Another fifteen clients had either dropped out of school or had been expelled. In twelve other cases the school had reported that they were in constant trouble and were real disciplinary problems. Although we would have clearly expected otherwise, only a very small number of the clients had frequent absences reported. Perhaps the most striking observation here is that in only three cases out of the ninety-one did we find no school problem reported.

Many of the clients not only had emotional problems, but physical defects as well. Twenty-three of the fifty-seven males had at least one physical defect. Among the females physical defects were even more common. Here we found that twenty-two of the thirty-four females in the sample had at least one physical handicap. The physical impairments included such disabilities as poor vision, stammering, obesity, epilepsy, and rheumatic fever. Obesity was the most frequent defect mentioned. Whether this is related to the physical handicaps or to their emotional problems it is not possible to determine, but a very high proportion of the clients had attempted suicide. Such attempts were more frequent among the female than the male clients. Five of the thirty-four female clients had attempted suicide. In one case two attempts had been made. Three of the male clients had at one time or another attempted suicide also. Here, too, it is evident even though the clients are referred to the agency at a very young age, they had very serious problems.

Nearly half of the clients had received some type of psychiatric help prior to referral to the DVR Project. The most frequent referral had been to the Butler Health Center. This type of help had been received by thirteen of these ninety-one clients. Twelve other clients had received help in the Mental Hygiene Program. The type of psychiatric help received prior to referral to the Demonstration Project is shown in Table 27.

TABLE 27.

TYPE OF SERVICE RECEIVED PRIOR
TO REFERRAL ON SCHOOL PROJECT

Source of Service	No. Clients
Butler	13
Medical Center--State Hospital	3
Mental Hygiene	12
Child Guidance Clinic	8
Private Psychiatrist	9
Rhode Island Hospital	6
Child Welfare Services	3
Family and Children's Service	3
Chapin	2
Bradley	2
Meeting Street School	1
Other	1
Total	63

About two-thirds of the clients who had received help had done so from only one agency, however, the remaining one-third had received help from two or more agencies before they were referred on the School Project.

The psychiatric diagnosis for the clients which were made on the basis of diagnostic services provided by DVR are shown in Table 28.

TABLE 28.

TYPE OF PSYCHIATRIC DIAGNOSIS BY SEX

Psychiatric Diagnosis	Female	Male	Total
Total Number	34	57	91
Personality Trait Disturbance	20.6	21.1	20.9
Adjustment Reaction of Adolescence	38.2	35.1	36.3
Schizophrenia	5.9	15.8	12.1
Chronic Brain Syndrome	8.8	3.5	5.5
Schizoid	11.8	8.8	9.9
Depression	2.9	- -	1.1
Psychoneurosis	11.8	12.3	12.1
Character Disorder	- -	3.5	2.2
Total Percent	100.0	100.0	100.0

About one-fifth of the clients were diagnosed as having personality trait disturbances. This was about as frequent among males as females. The most frequent diagnosis fell in the category "Adjustment reaction of adolescents." In this category we found slightly more than one-third of the clients. Here, too, the sexes were about equally represented. Although "Schizophrenia" was reported in only a minority of the cases, it was much more frequent among males than females. On the other hand, females had a high disproportionate number in the "Chronic brain syndrome" and "Schizoid" categories. "Psychoneurosis" was the diagnosis for 12 percent of the cases and this, too, was about equally frequent among both the male and female clients.

We now turn to the prognosis which followed the psychiatric diagnosis.

TABLE 29.

PROGNOSIS BY SEX

Prognosis	Female	Male	Total
Total Number	34	57	91
Excellent	8.8	7.0	7.7
Good	50.0	35.1	40.7
Fair	26.5	22.8	24.2
Doubtful--Poor	2.9	28.1	18.7
No Data	8.8	7.0	7.7
No Help Needed	2.9	- -	1.1
Total Percent	100.0	100.0	100.0

In only a small proportion of the cases was the prognosis excellent, but it is noteworthy that in nearly half of the cases the prognosis was good or better. It is particularly interesting to note that the prognosis for the females was considerably more favorable than for the males. We found that the prognosis was good or better for 60 percent of the females, but only 42 percent of the males were so characterized. On the other hand, while a doubtful or poor prognosis was given for less than 20 percent of the total cases in the sample, this ranged from less than three percent among the female clients to 28 percent among the male clients. It is quite evident that the prognosis for females was considerably more favorable than that for males.

We turn now to a discussion of the types of services provided the clients in the sample. We have already noted that the prognosis was much more favorable for females. When we examined the diagnostic services provided we found that nearly all of the females had a psychiatric evaluation compared with only eight out of ten of the males. On the other hand, psychological testing and neurological evaluations were more frequent among the male clients.

For the total sample the most frequent evaluation services offered were psychiatric evaluations and general medical examinations, in that order. Psychiatric evaluations were offered to seventy-nine of the ninety-one clients while seventy-one were given general medical examinations. Psychological tests were given to more than one-half of the clients. Thus for most of the clients the diagnosis and prognosis were determined largely on the basis of these three evaluations. In none of the other evaluation categories did we find as many as ten percent of the clients receiving that type of service. Within each of these diagnostic service categories evaluations were more frequent among female clients. Workshop evaluations in particular were more frequently used for the female clients.

While evaluation services were more extensive among the emotionally disturbed females, the frequency of psychotherapy treatment was highest among males. More than four-fifths of the males received psychotherapy whereas only two-thirds of the females received such treatment. On the other hand, Day-Care services were much more frequently used for the female clients. Only five percent of the males as compared with 18 percent of the females were in the Day-Care program. The only other sizable difference between the sexes was in reference to those receiving prothesis. This was provided for 12 percent of the females but none of the males. In short, for the total sample, three-fourths of the clients with psychological disabilities received psychotherapy. About one client out of ten was treated in the Day-Care program. Speech therapy was provided for nearly eight percent of the clients. All other forms of treatment were used less frequently.

Further formal education was the most frequent type of training provided. For one client out of four "school or college" training was provided. In addition "special courses" or "remedial reading or tutoring" were provided in the treatment of seven percent of the male and nearly one-fourth of the female clients. Altogether females were more frequently provided further training in the broad field of education than were the male clients with the same general disability. The difference no doubt was due in part to the more promising prognosis for females. That is, the counselors felt that the females were more likely than the male clients to respond favorably to such training. Females were also more frequently offered training in the workshop program. In short, the sample population received a battery of psychological evaluations, and were provided treatment through psychotherapy and the Day-Care program, and training through further formal education or remedial education.

Another way to view the services provided is to examine the number of services offered and the average costs. Less than 15 percent of the clients received only one or two services from the program. For the six clients who had received only one service the average cost to the Project was approximately $150. The average costs increased to $231 for the seven clients who had received two services. It is noteworthy that 85 percent of the clients, at the time of the survey, had already received three or more services through the agency. Since these are active cases the amount and range of services will likely continue to increase over time. Actually about half of the clients had received three or four different services at an average cost of about $700 per client served. These data illustrate the extensiveness of the services offered by this program. Further evidence of this is shown by the large proportion of clients that had received five or more different services at an average cost of more than $1500 per client. More than one-third of the clients had received five or more services.

At the time of the survey of this sample population the agency had provided a wide range of services for the ninety-one clients. These services had been purchased from the community at a total cost of more than $86,000. Thus the average expenditure per case was only slightly less than $950. This, however, was due in part to a small number of very large expenditures as is evident from the data shown in Table 30. The most frequent expenditure per client ranged between $500 and $1,000 for females but under $500 for males. We found that less than $500 was spent on 42 percent of the males, whereas only 29 percent of the females are in this category. Female clients were disproportionately over concentrated in the $1,000 to $1,999 category while males were more concentrated in the highest expenditure category. Thus while nearly 15 percent of the males received services which cost the agency more than $2,000 only six percent of the female clients cost the agency this amount. In short, the male clients tend to be found disproportionately in the extreme categories while the range for females is much more limited. The latter tend to be concentrated in the middle expenditure categories. Here we found 65 percent of the females but only 43 percent of the males.

TABLE 30.

DISTRIBUTION OF EXPENDITURES BY SEX

Expenditures	Female	Male	Total
Under $500	29.4	42.8	37.8
$500 to $999	35.3	28.6	31.1
$1,000 to $1,999	29.4	14.3	20.0
$2,000 and Over	5.9	14.3	11.1
Total Percent	100.0	100.0	100.0
Median	$ 791	$ 625	$ 661

The median expenditure to date has been 40 percent higher for female than for the male clients, that is, $791 as compared with $625. As already noted, this average expenditure is misleading since the distribution of expenditures differs significantly by sex. The range of expenditures for females was much less than for the male clients. At any rate these data demonstrate the amount of support the agency has provided for this sample of clients through the purchase of services in the community. These data imply that the agency provided whatever services are needed to correct the disability.

There is obviously a wide range in type as well as the amount of services needed. This judgment is made for the agency by the counselor through the advice gained in the diagnostic examination reports. Treatment services were then provided as needed. In some cases the costs were high because of the seriousness of the problem. It is the philosophy of the agency that in the long run, if the treatment is successful the costs will prove to be small in terms of the help received. When one takes into account the type of disability present in this sample population, and the needs of the clients, it is evident that the range of services provided by the agency and the costs of these services would in most cases be beyond the resources of the individual client's family; yet the investment by the agency is small when viewed in terms of the potential returns, both for the individual and society, which would result if the client can be "rehabilitated" at this early age. If the agency prepares a troubled client so as to be able to fully participate in the labor force when the client becomes of age, the life of the individual and his family will be markedly improved and the savings to society will be substantial. This then leads us to examine the results of the services that have been provided.

At the time of the survey the results of the services provided showed that very substantial progress had been realized. According to the data shown in Table 31, more than two-fifths of the females and nearly half of the males had shown "very satisfactory" progress, and slightly more than one-fifth of both sexes had shown "quite satisfactory" progress. When these two categories are combined it is noted that 63 percent of the females and 70 percent of the males had shown signs of improvement. Of these most had shown "very satisfactory" progress. On the other hand a substantial minority of the clients had not responded favorably to the services provided. About one client in five did not show any progress or at best only slight improvement. For about half this number, slightly more than one in ten, it was felt that the agency had not been able to help the client with services which would overcome the handicap of his disability.

TABLE 31.

EVALUATION OF PROGRESS BY SEX

Evaluation	Female	Male	Total
Total Number	34	57	91
Very Satisfactory Progress	41.2	47.4	45.1
Quite Satisfactory "	20.6	22.8	22.0
Little or No Progress	20.6	17.5	18.7
Unable to Help	11.8	10.5	11.0
No data	5.9	1.8	3.3
Total Percent	100.0	100.0	100.0

Again, if we consider the seriousness of the problems which brought these clients to the agency, the above results are both impressive and promising. These data seem to support the notion that much can be accomplished through the services provided by this Project to improve the life conditions of the clients by working with them at an early age. It will be recalled that a substantial majority of the clients under discussion were referred to the agency when they were either fourteen or fifteen years of age. While all are still on the program as active cases, the data shows that for a majority real improvements had been realized. Some who had dropped out of school had returned to school, and many of those who were in difficulty in school showed marked improvement in conduct.

The long run and far reaching implications of what this program has accomplished for one of the clients and the members of his family is illustrated by a close examination of an individual case history. This case is presented in detail because it suggests that this Project has successfully broken the "culture of poverty" cycle through the provision of services which were "preventive" in nature, and not only successfully resolved an emotional problem but adequately prepared the client for full participation in the labor force.

In January 1962, the first year of the School Project, a seventeen year old, well-built, but extremely nervous boy was referred to DVR due to an emotional problem complicated by enuresis which interfered with his satisfactory achievement in high school. The client was the oldest of eight children, all but one of whom were enuretic. He lived in a crowded, run-down house with his parents, siblings, and an eighty-seven year old grandmother. One brother was also a DVR client. The father who was forty-nine years of age was, according to the counselor, a "rather intelligent" man. However, the father had not worked regularly for many years. During recent years he had received $35 bi-weekly in Aid to the Disabled, which was the family's sole means of support. The father had periods when he became addicted either to barbituates or alcohol and at times to both. He has been hospitalized at Chapin Hospital and the State Hospital for Mental Diseases on three occasions. The client's father, according to the counselor's report, voiced concern to the counselor about his economic dependency, but he showed little emotional concern and made no effort to obtain employment. Particularly during recent years a growing conflict developed between the client and his father. The father's attitude and behavior toward the client fluctuated between extreme overindulgence and extreme anger. The turmoil in the family was so extreme that on several occasions the police had been called to the home.

At the time of referral to the School Project the client's mother was pregnant once again. According to the counselor she appeared to be a quiet, easy going woman, and it was largely through her efforts that the family was held together. However, some months earlier she had a severe bout of tuberculosis which required hospitalization at Wallum Lake. This then provides a rough description of the home environment in which the client lived.

Although the client had been doing fairly well in his school work prior to entering high school, despite difficult and unpleasant living conditions at home, he became unable to cope with the school situation at the high school level. He was suffering from inferiority feelings and was unable to adjust to his peers. Shortly before his referral to the agency he had been a star track man at school, and was deeply hurt when he was not elected

Co-Captain of the team, which he felt he had deserved. At the time of his referral to DVR, the client was emotionally disturbed. He felt that he was unable to continue in school due to his illness and was anxious for help. The examining physician, who performed the general medical, was aware of the youngster's desperate home condition, writing that "due to dire economic circumstances this young man has suffered embarrassment with his classmates." The physician also noted, however, that the client really wanted "to finish high school and develop himself as much as possible." The physician recognized the scope of the problem and urged the agency to help the boy. The examining psychiatrist was also very familiar with the family background of the client since he had treated the father earlier. In the psychiatric examination it was noted that the boy "had lost the point in life and that to do anything was quite an effort." The psychiatrist felt that the boy would be difficult to treat but nonetheless stated that "in spite of the severe handicap he is under in his background, I think that the boy cound be helped on an office basis." Despite his general unhappiness, illness, and despair, the youngster showed a genuine motivation to continue with school and graduate despite the many pressures with which he had to contend.

The DVR counselor worked closely with the youngster, and it was decided that when he returned to school that he would switch to another high school outside the neighborhood in order to avoid the embarrassment he felt, and to begin over again in a new environment. By this time he was in his senior year. The year did not begin encouragingly, as he was absent a great deal due to illness and the family's needs at home. On the basis of the recommendation of the psychiatrist he was hospitalized at Butler for a short time in order to have his medication regulated. While living at the hospital he attended school regularly. During this time his grades made a significant improvement. Although the psychiatrist reported that the boy was "sick," he felt "he appears to have some very good assets," and it would be good if arrangements could be made to get him out of his home environment. With the assistance of the DVR counselor and the school guidance counselor, the client explored the possibility of attending college. His greatest ability was in physical education, which he wanted to teach. He applied to three different colleges including one of the public colleges in the state. While he was not accepted at two of the colleges, he was accepted at the University of Miami.

Although the costs at Miami were considered very high, this case was carefully discussed by the counselor, supervisor and medical consultant. It was felt that since the client showed a sincere desire to attend college some distance from home and was determined to accomplish his goal, he should be afforded this opportunity. The home situation had remained largely unchanged. The client continued under unusual stress. It seemed that the only way that he could break away from the family dependency was to leave home. The DVR counselor concurred in this judgment. The client was given complete expenses for tuition, books, and living accomodations. He adjusted readily to college life, and did quite well during his first year, only slightly missing the dean's list. Later he decided that the physical education program was unchallenging, thus changed to a Liberal Arts program, where he intended to major either in philosophy or sociology.

While at college he made friends easily, was very happy, maintained a parttime job in the bowling alley to earn money for his clothing and his transportation home. When he was home during the summer months he had many contacts with the DVR counselor. He continued to find the home situation upsetting. In his report to the counselor, conditions had even become worse. Milk was scarce; his father was beating his mother; the youngsters were not being cared for. He felt that perhaps he should be close to the family and thought about transferring to the University of Rhode Island, but was encouraged by the DVR counselor to stay as far away as possible. He followed this advice and returned to Miami when college classes opened.

In April 1964, an inter-agency conference was held concerning this family. It was pointed out that in the last fourteen years that Public Assistance had been working with this family, "every medical, social, and financial advantage" was offered to the father, however, most plans for self-sufficiency were "refused." As was evident from an examination of his file, he has been repeatedly offered the "very best of possibilities and facilities" for evaluation and treatment of his problem. He has constantly failed to avail himself of any of these. The inter-agency conference recommended an evaluation on an in-patient basis and concomitant withdrawal treatments at the Mental Health Institute. The conference members agreed that "it would appear futile to attempt this at any out-patient facility or to continue to support his own attempts at seeing one doctor after the other in the community .... it is most likely that this would ultimately also be of benefit in helping the entire family to get better organized. The mother would be under less pressure, might feel better and need less treatment herself. More constructive plans could also be made for the children ..." It was concluded further that if the father did not accept this offer for evaluation any more than the previous ones, that "an administrative decision would be necessary informing him of the fact that the Division of Public Assistance could not support any further his own way of seeking treatment which has been unsuccessful and is contrary to the deliberate medical opinions available."

Throughout the client's college days he maintained steady contact with his DVR counselor. By his junior year he had decided to major in Sociology because of his interest in social work and, considering his deprived cultural background, he did quite well scholastically. While most of his grades were above average, he did particularly well in his major field of interest. He continued to work parttime while at school and worked in construction during the summer. In short, he made a good adjustment. He spoke to the counselor about his plans to help his family by being better qualified to compete for a better job as a college graduate. He was objective about his family. He married a local girl just before his senior year, and lived in college facilities for married students. He successfully graduated from the University of Miami in June 1967, after four years. The client returned to Rhode Island immediately and received a job as a social worker for the Progress for Providence program and is currently earning $125 a week. He applied and was accepted at NYU and the University of Connecticut School of Social Work. He received a full fellowship at the latter providing his complete tuition and living expenses. His wife is a secretary for the State of Rhode Island and will continue to work. They do not plan to raise a family at once, but are considering having his two younger brothers live with them.

The client was interviewed recently and was eager to discuss his case. The interviewer noted that "he is a tall, handsome, well-groomed young man who very openly and freely discussed his earlier years." He feels very grateful to DVR, and knows that without the financial and moral support he received from the agency he could not have graduated from college. He would not have been eligible for a regular scholarship because of the inconsistency in his high school record as well as low grades on the college boards. He felt that DVR was willing to give him a chance despite his poor school record, and because of this he was determined to succeed. At first he experienced guilt feelings about leaving his family, which he felt needed him, however, he knew that his only chance of really helping them was by becoming better educated. He feels very fortunate that many people seemed to be interested in him as he was growing up and encouraged him. Those mentioned specifically were a ballplayer, a priest at LaSalle Academy, his psychiatrist, and his DVR counselor. He felt that he was "luckier" than most people in his economic condition because he was given "many breaks," but obviously there was something about this young man that made people want to help him. He was never too tired to work, whether it was at school or in construction. He was desperately poor while at college ....yet he managed to send a few dollars of his earnings to his mother every week. He feels that his father is sick but selfish; ungrateful for everything the state has given the family, and wants all that he can get without doing a thing. Although the parents were proud of him, he now feels that they are resentful and a little jealous that he has pulled himself out of their living conditions. He sees them regularly, gives them help, and they are glad to have him take the younger children. He feels that he had to leave the family in order to become independent. Up until the time he left for college he felt great responsibility for the family and was chained to their poverty, filth and deprivation. When he got to Miami he was well accepted, met people from all over the country, and became aware of the vast opportunities open to him, and he knew that he would not live in abject poverty and despair. The client felt that the financial aid provided by this agency (which in this case was very high--$7,365.17) made his education possible. The counseling was also imperative.

With the counselor he first explored the various areas open to him professionally and thoroughly discussed the possibility of a career in social work. The DVR counselor also was always available to provide moral support and encouragement. The client visited the counselor each time he was at home, and made excellent use of the Project. By this closure it appears that the Public Assistance way of life has been successfully broken. It is interesting to note that a younger sister is now on the program and is attending one of the colleges in the state where she too is doing well and wants to become a teacher.

CLOSED CASES: A REVIEW AND APPRAISAL

Social service statistics do not lend themselves to easy record keeping nor do the statistics, no matter how skillfully recorded, analyzed or presented, give either an accurate or a full account of the accomplishments of the services provided. The account here is no exception. It has been the tradition for the Division of Vocational Rehabilitation to use closed cases as an index of their accomplishments. This, of course, is not a valid index because the agency can and does contribute substantially during the treatment period to the well being of the client and his family, but as long as the client remains an active case, it is not counted as a success. There has not been developed a technique whereby the effective functioning of the agency can be portrayed through the services that it renders. It is apparent that there is a real need to develop methods of reporting that properly reflect what the agency is doing.

Much less attention, particularly in this Project, should be placed on closed cases because frequently these are not a real measure of success. By the very nature of this particular program it is evident that to keep the client in school is a major goal and represents successful results. Yet this major accomplishment would not show up in the statistics of closed cases. Also, since the clients are taken into the program at a very young age, it is necessary to carry them on the program for years before they are even old enough to enter the labor force. Thus to depend on closed employed as the index of the successful functioning of the Project is to misrepresent the accomplishments of the agency. For example, if through the services provided by the agency the client makes a successful adjustment to life, which is reflected in his ability to remain in school not only at the secondary level but to go on to the college level, the problem should be judged as highly successful. However, this would not be reflected in the statistics on closures.

One might even argue that closures at an early age represent a failure on the part of the agency to treat the client in a manner so as to permit him to reach his full potential. It would be foolish to imply that this argument applies in all cases, for many of the clients are not capable of the work that is demanded in the schools even at the secondary level, thus to become employed in the labor force is a substantial accomplishment. This then leads us to caution the reader about the real meaning of the data presented in this section. The nature of the data is such that there is no way of really knowing what they mean. We do know, however, that many of the clients that responded very favorably to the services provided by the agency are not included here because they are still in school. Eventually these are the cases which in the long run will prove to be the most successful and the ones that profited most from the help they received from the Demonstration Project.

The purpose of this Project is to identify problems at an early age and take preventive measures so that the client will be prepared to enter the labor force when he becomes of age. This being the goal, it becomes evident that one of the major objectives is to treat the client so that he will remain in school and thus be equipped to enter the labor force and become competitive, at least in terms of education. On the other hand, the traditional goal of the agency is to treat the client in such a way that he can become employed. The latter remains the primary goal of this Project also, but it is a long deferred goal because of the age of the clients at the time of referral. Because of the dual goals of the Project, the data on closed cases have only limited value and the meaning is uncertain. However, closed employed represents the clients that have received services from the agency and have found jobs in the labor force. These data represent only the minimum accomplishments of the Project since, as noted above, when those who have been able to remain in high school or in college complete their education and enter the labor force, the record of the agency will be much more impressive. While the data on closed cases have many shortcomings, they nonetheless merit presentation since they reflect part of the functioning of the agency. Through a close examination of these cases we can view some of the work of the agency.

In Table 32 is shown the number of closures per year since the inception of the Project. As one would expect, there were few closures during the first year, but the number increased substantially over the five-year period. In the fifth year of the Project more than 700 cases were closed. Altogether nearly 2,300 cases were closed during the five-year period. However, as shown in Table 33, only about half of the closed cases were employed, while a nearly equal number were closed after referral. The ratio between closed employed and closed referred remained rather constant throughout the first three years, but the proportion that were closed referred declined during the last two years. This is shown in Figure 5.

TABLE 32.

NUMBER OF CLOSURES BY YEAR OF CLOSURE

Year of Closure	Number of Closures During Year	Number of Closures to Date
1962-63	139	139
1963-64	288	427
1964-65	535	962
1965-66	583	1,545
1966-67	717	2,262

TABLE 33.

NUMBER OF CLOSURES BY TYPE AND YEAR OF CLOSURE

Year of Closure	Type of Closure		
	Employed	Referred	Other
1962-63	63	68	8
1963-64	137	142	9
1964-65	251	263	21
1965-66	309	242	32
1966-67	342	308	67
Total	1,102	1,023	137

Throughout the five years of the Project about 1,100 clients had successfully entered the labor force. More than half of these were closed during the past two years. If one were to examine these data in another year or two, one would find a sharp increase in the number of "closed employed" as the clients become of labor force age or as they complete their schooling. It is clear that the full impact of the Project on the lives of these people cannot be measured at this time since many of the clients are still too young to enter the labor market.

In Table 34 we find that the type of closure varied substantially by type of disability. The proportion of clients that were closed employed ranged from a high of 90 percent of those whose disability was classified as "psychosis" to a low of only 33 percent whose disability was "psychological." Those with orthopedic disabilities also show a disproportionately large number of "closed employed." Actually, when the total closures are broken down by type of disability, we find a majority of closed employed among all disabilities except those in the psychological and other categories.

TABLE 34.

TYPE OF CLOSURE BY TYPE OF DISABILITY

Type of Disability	Total Number	Closed Employed	Closed Referred	Closed "Other"	Total Percent
Total	2,263	1,104	1,023	137	
Orthopedic	186	73.1	18.8	8.1	100.0
Vision	99	60.6	26.3	13.1	100.0
Hearing	115	56.5	40.9	2.6	100.0
Speech	53	56.6	35.9	7.5	100.0
Psychosis	139	89.9	5.8	4.3	100.0
Mental Retardation	349	64.2	31.2	4.6	100.0
Psychological	959	32.7	61.5	5.7	100.0
Other	358	41.9	52.5	5.6	100.0
Total		48.8	45.2	6.0	100.0

The high proportion of "closed referred" among those in the psychological category likely represents, in part, the vagueness of this classification and the high proportion of merely "school behavioral problem" cases that are referred in this category. In the early stages of diagnosis it was frequently found that these cases did not represent the type of problem that either needed or would have benefited from the type of services provided in this program. Of all of the cases referred by the schools, psychological disabilities were the most numerous, but also the most heterogeneous. They covered a wide range of problems, many of which were behavioral problems that disrupted the schools rather than psychological disabilities in need of professional

FIGURE 5.

NUMBER OF CLOSURES

BY TYPE AND BY YEAR

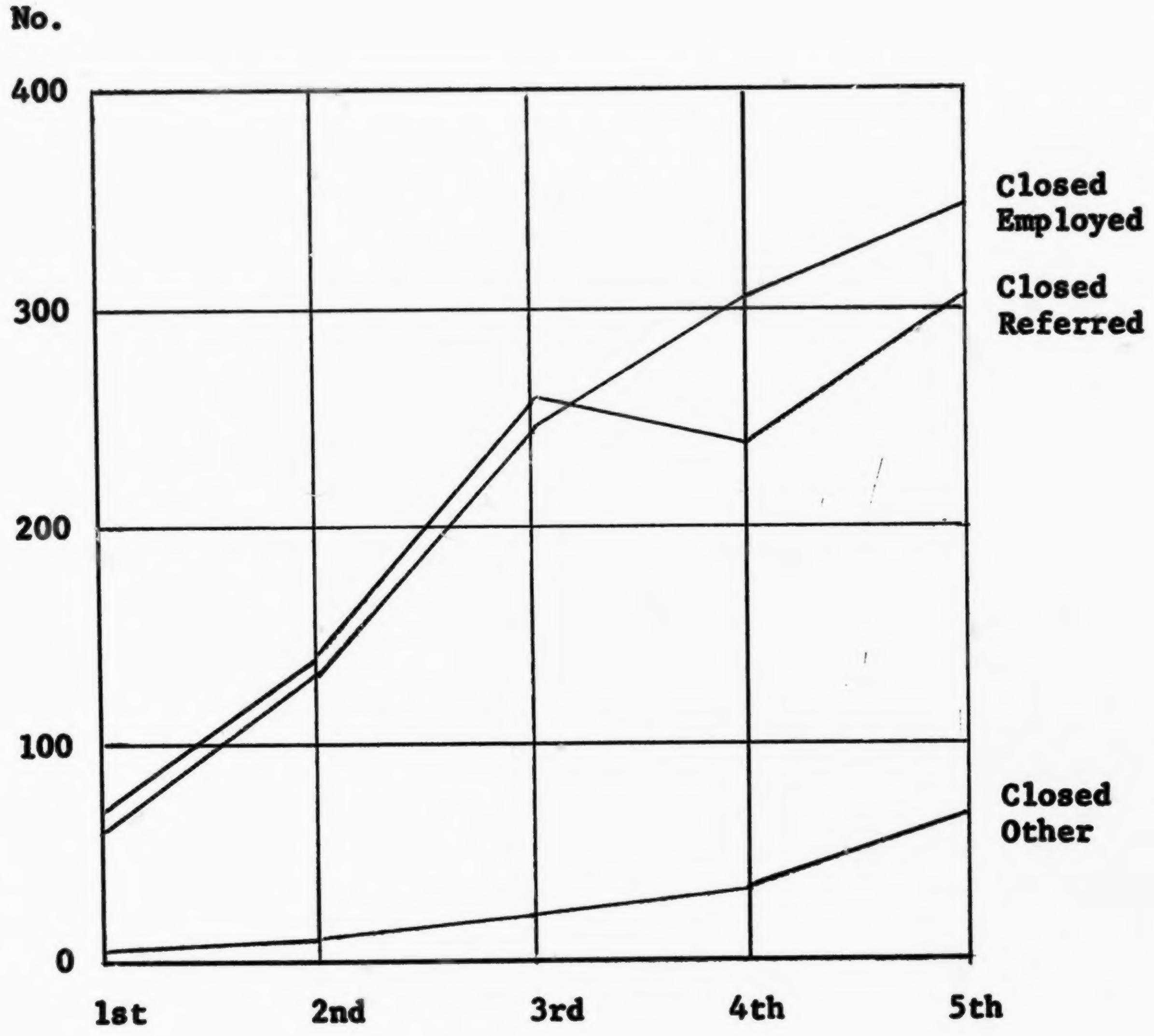

TABLE 35.

NUMBER AND TYPE OF DIAGNOSTIC SERVICES PROVIDED AND AVERAGE NUMBER OF SERVICES PER CLIENT

(CLOSED EMPLOYED)

Disability	Number of Clients with Disability	Services Provided		Type of Service Provided			Average Number of Services Per Client
		Number	Percent	Psychological	Medical	Prothesis	
Orthopedic	135	176	100.0	29.0	68.8	2.2	1.3
Vision	61	75	100.0	24.0	68.0	8.0	1.2
Hearing	64	96	100.0	20.8	61.5	17.7	1.5
Speech	29	39	100.0	28.2	71.8	- -	1.4
Psychosis	123	158	100.0	28.5	71.5	- -	1.3
Mental Retardation	222	328	100.0	40.5	57.9	1.5	1.5
Psychological	312	453	100.0	33.8	65.8	0.4	1.5
Other	146	179	100.0	31.3	68.1	0.6	1.2
Total	1,092	1,504	100.0	32.4	65.3	2.3	1.4

treatment, consequently there was considerable waste in processing these cases. While they added to the burden of diagnostic services, such cases did not place heavy demands on treatment services. These, of course, represented problems that were difficult for the school counselor to properly evaluate. Thus it is understandable that such clients should be referred to the agency. However, as shown in Table 34, a majority of these cases were closed following the diagnostic examination. Apparently the referral system is much more efficient for the other disabilities, for we find only a small minority of the cases were found in the closed referred category. This means then that a majority were accepted for treatment and later were closed after they had found employment.

The type of diagnostic services that had been provided for the closed employed clients is shown in Table 35. In general, psychological examinations accounted for one-fourth to one-third of the diagnostic services regardless of disability. It is only among the mentally retarded that a high disproportionate number of cases were given psychological examinations. A majority of the diagnostic services in all disability categories were medical examinations. Two-thirds of the diagnostic services provided were in this category. It was only among those with vision and hearing disabilities that prothesis services were frequently provided.

In the last column of Table 35 we find the average number of diagnostic services provided by type of disability. These data indicate that on the average the closed employed clients received 1.4 diagnostic services. This ranged only slightly by type of disability.

Turning to Table 36 we find that there were considerable differences between the diagnostic services provided for the closed employed and those who were closed referred. However, it is evident that even the latter have placed considerable demands on the facilities of the agency, but they did much less so than those who were accepted for treatment and were closed employed.

Among the closed employed 44 percent received psychological diagnostic services at an average cost of nearly $138. By way of contrast, we find only 17 percent of the closed referred received this particular service. Among the latter the average costs were less than half the amount spent on the closed employed, that is, $63 versus $138. A very similar difference by type of closure is also found with respect to medical diagnostic services. While a much larger proportion of both groups received this type of service, the average cost of the service was substantially less. About 90 percent of the closed employed received medical diagnostic services as compared with 61 percent of those in the closed referred category. The average expenditure per client served was nearly twice as high for the closed employed as for the closed referred.

If we view the diagnostic expenditures for the total number of clients in each category, we find even larger differences. The total expenditures for diagnostic services for the closed employed was $100 as compared with an average of $23 for those in the closed referred category. However, the latter figure is highly significant because it shows the demands that are placed on the agency just to process clients that have been referred but who either are not in need of the services offered by the agency or their problems are such that the agency would not be able to effectively treat them. While this function is essential in the day-to-day operations of the Project, it is not the type of activity that readily shows in the accomplishments of the agency.

TABLE 36.

NUMBER OF DIAGNOSTIC SERVICES, COST OF SERVICES AND AVERAGE COSTS PER CLIENT SERVED BY TYPE OF SERVICE AND TYPE OF CLOSURE

Type of Service	Closed Employed	Closed Referred
Psychological		
Number Served	487	173
Costs	$67,089	$10,839
Average per Client Served	$137.76	$ 62.65
Medical		
Number Served	991	622
Costs	$35,781	$12,364
Average per Client Served	$ 36.11	$ 19.88
Prothesis		
Number Served	35	*
Costs	$ 5,956	
Average per Client Served	$170.17	

* Only one case at cost of $270.

In Table 37 we find the proportion of medical and training services that were devoted to each type of disability. These data are limited only to the closed employed. It is evident, as one would expect, that the type of treatment provided varied substantially by type of disability. Those with psychological disabilities, and those classified in the psychosis category, accounted for more than two-thirds of the total medical services offered but only about one-fourth of the training services. On the other hand, those with orthopedic disabilities accounted for only 10 percent of the medical services but nearly one-fourth of the training cases. Similarly, mental retardation clients absorbed a high disproportionate amount of the training that was offered. While the mental retardates received only 6.5 percent of the medical services, they accounted for 20.5 percent of the training services. The wide variety of disabilities grouped in the "Other" category placed more of a demand on the training services offered as treatment than on the medical services.

Turning our attention to Table 38, we also find that the cost of treatment varied markedly by type of disability. On the average the most costly

TABLE 37.

NUMBER AND PERCENT DISTRIBUTION OF MEDICAL TREATMENT AND TRAINING SERVICES PROVIDED BY TYPE OF DISABILITY

Type of Disability	Medical Services		Training	
	Number	Percent	Number	Percent
Total	307	100.0	370	100.0
Orthopedic	31	10.1	88	23.8
Vision	6	2.0	20	5.4
Hearing	8	2.6	27	7.3
Speech	15	4.9	8	2.2
Psychosis	55	17.9	26	7.0
Mental Retardation	20	6.5	76	20.5
Psychological	153	49.8	68	18.4
Other	19	6.2	57	15.4

TABLE 38.

PERCENT DISTRIBUTION OF COSTS OF MEDICAL TREATMENT AND TRAINING SERVICES AND AVERAGE COSTS PER SERVICE BY TYPE OF DISABILITY

Type of Disability	Medical Services		Training	
	Percent	Average Costs	Percent	Average Costs
Total Number	103,404	$ 340	318,772	$ 890
Orthopedic	13.6	453	27.2	984
Vision	0.8	143	6.7	1,071
Hearing	0.6	77	4.3	511
Speech	3.5	232	4.0	1,581
Psychosis	17.4	327	4.5	549
Mental Retardation	7.1	366	17.8	744
Psychological	52.9	357	15.7	736
Other	4.1	224	19.8	1,110
Total Percent	100.0		100.0	

TABLE 39.

NUMBER AND PERCENT DISTRIBUTION OF COSTS OF MEDICAL TREATMENT SERVICES PROVIDED AND AVERAGE COSTS PER SERVICE BY TYPE OF SERVICE

Type of Service	Services Offered		Cost of Services		Average Costs Per Service
	Number	Percent	Dollars	Percent	
Total	307	100.0	103,384	100.0	$ 340
Surgery	19	6.2	5,840	5.6	307
Dental	15	4.9	4,088	4.0	273
Psychiatric	157	51.1	48,176	64.6	309
Day-Care	43	14.0	29,328	28.4	696
Physical Therapy	1	0.3	65	0.1	65
Speech Therapy	17	5.5	1,834	1.8	122
Hospitalization	21	6.8	11,204	10.8	558
Transportation	21	6.8	1,656	1.6	79
Other	13	4.2	1,193	1.2	85

TABLE 40.

NUMBER AND PERCENT DISTRIBUTION OF TRAINING SERVICES PROVIDED AND AVERAGE COSTS PER SERVICE BY TYPE OF TRAINING

Type of Training	Training Offered		Cost of Training		Average Costs Per Service
	Number	Percent	Dollars	Percent	
Total	371	100.0	330,248	100.0	$ 890
College	76	20.5	152,362	46.1	2,005
Junior College	24	6.6	16,168	4.9	674
Business	55	14.8	38,970	11.8	709
Trade	53	14.3	48,141	14.6	908
On-the-job	15	4.0	3,842	1.2	256
Workshops	87	23.4	59,236	17.9	681
Reading-Tutoring	17	4.6	2,671	0.8	157
Camp (Dr. Rossi's)	44	11.8	8,858	2.7	201

medical services were for those clients with orthopedic disabilities. For the client served the average costs exceeded $450. Similarly, the average costs were high for the mentally retarded and those in the psychological and psychosis categories. In all other disability categories the average costs for medical treatment were less than $200. The least costly disabilities for medical services were those in the hearing category.

In the treatment process training was much more costly than medical services. The average expenditure per client served exceeded medical costs nearly threefold. While the average costs for medical services were only $340, training costs on the average amounted to $890. Training costs varied substantially by type of disability. The average costs ranged from only slightly more than $500 for those with hearing disabilities to more than $1,500 for those with speech problems. However, both of these categories contain only a small number of cases. All of the cases in the two disability categories combined accounted for only 8 percent of the total training costs.

It was the orthopedic disabilities that placed the greatest demands on the training program. The average expenditure on these cases amounted to $984. This category alone absorbed more than one-fourth of the total training expenditures. While the average costs per client serviced were somewhat lower among those in the mental retardation ($744) and psychological ($736) disability categories, these accounted for one-third of the total expenditures for training. Clearly, then, the major expenditures for training were devoted to three disabilities: orthopedic, mental retardation, and psychological. One-fifth of the training expenditures were devoted to the variety of disabilities found in the "Other" category.

We turn now to an examination of the type of treatment provided. As shown in Table 39, most of the medical services offered were psychiatric. More than half of the clients receiving medical services were provided psychiatric treatment. This treatment alone accounted for 47 percent of the expenditures. The next most frequent, as well as most expensive, service was the Day-Care program. While this accounted for only 14 percent of the medical treatment services offered, it absorbed 28 percent of the total expenditures. Thus psychiatric treatment and Day-Care accounted for three-fourths of the total medical treatment expenditures. The average costs per client served were $309 for those receiving psychiatric treatment but nearly $700 for those in the Day-Care program. Clearly the latter is the most expensive treatment offered. Hospitalization is the second most expensive, where the average costs exceeded $550, but this was less frequently provided and accounted for only 11 percent of the total medical expenditures.

The average medical costs per client served amounted to $340, but, as noted earlier, training costs were much higher. According to the data shown in Table 40, one-fourth of the clients received college training and another 15 percent received business school training. Of those who attended college, most attended a regular four-year college. This was clearly the most expensive training provided. The average costs per client attending a four-year college exceeded $2,000. This type of training accounted for nearly half of the total cost of training. For those attending junior college the average costs were less than $700, which is only slightly less than the amount spent on those who attended business school. When we combine the three levels of higher education (college, junior college and business), we find that more than 60 percent of the costs of training were expended in these categories.

Workshops accounted for 23 percent of the number of clients receiving training but only 18 percent of the costs. The average costs per client served amounted to $681. Trade school training was less frequently provided but the average costs were considerably higher. The average costs exceeded $900. On-the-job training was infrequently used and was less costly. Twelve percent of the clients receiving training were sent to Dr. Rossi's Camp (see description) at an average cost of approximately $200. This type of treatment made up less than three percent of the expenditures for training.

Throughout the five-year period of the Demonstration Project the agency expended more than $425,000 for treatment. Of this amount one-fourth was spent for medical treatment, with a heavy emphasis on psychiatric services, and three-fourths on training, with a high disproportionate amount being spent on higher education. During the last year of the Project an even larger proportion of the total expenditures were for training, thus reflecting somewhat a change in emphasis. The amount expended for psychiatric treatment declined slightly whereas the amount devoted for higher education increased.

Attention is now turned to the type of jobs the clients obtained when they entered the labor force. For the most part these were jobs which the clients obtained through their own efforts. It is evident that a larger proportion of the clients entered occupations in the unskilled category than in any other single occupational group. As is shown in Table 41, nearly three out of ten clients are employed in unskilled occupations. However, as is shown below, much of this is due to the high concentration of the large number of mentally retarded in this category. Another twenty percent of the clients have either skilled or semi-skilled jobs, with the latter type occupations being more numerous. On the upper end of the occupational structure we find that nearly one-fourth of the clients obtained white collar occupations. Two-thirds of these, however, are in clerical positions, and slightly more than one client out of twenty holds a professional position. Nearly one-fourth of the clients are found in the "Other" category which includes service occupations, the Armed Forces and a variety of other comparable jobs.

TABLE 41.

OCCUPATIONAL DISTRIBUTION OF CLOSED EMPLOYED

Occupation	Number	Percent
Professional	58	5.2
Clerical	165	14.9
Sales	27	2.4
Skilled	84	7.6
Semi-Skilled	130	11.7
Unskilled	321	29.0
Self-Employed	4	0.3
Homemaker	63	5.7
Other	252	22.8
Total	1,104	100.0

As we pursued the analysis further by examining occupations by area of residence, we found that the status of the job held by the client tends to vary directly by the status of the area in which he lives. This part of the analysis is limited only to the clients living in the city of Providence since this is the only area for which the socio-economic status index is available. The clients have been tabulated according to census tract of residence and these in turn have been divided into three socio-economic status levels. In Table 42 is shown the occupational distribution of the clients by the socio-economic status of the tracts. Some rather marked and consistent differences are noted. For example, among those living in the high status tracts, more than one-third hold white collar jobs, but the proportion of such jobs decline to only 10 percent among those in the low status tracts. On the other hand, skilled and semi-skilled workers increase from only 10 percent in the high status to 28 percent in the low status tracts. Little or no differences are found among the other occupational categories. At any rate, there seems to be some consistency between the type of job held by the client and the type of jobs held by others living in the same socio-economic status areas. As the status of the area increases, so does the proportion of clients holding higher status jobs, and the difference is sizeable.

TABLE 42.

OCCUPATIONAL DISTRIBUTION OF CLOSED EMPLOYED
BY SOCIO-ECONOMIC STATUS OF CENSUS TRACT OF RESIDENCE

	Socio-Economic Status of Tract		
Occupation	High	Medium	Low
Total Percent	100.0	100.0	100.0
Professional	8.6	8.7	2.2
Clerical	25.8	9.6	5.6
Sales	- -	4.3	2.2
Skilled	3.4	7.8	10.2
Semi-Skilled	6.8	14.0	18.1
Unskilled	32.7	31.5	35.2
Self-Employed	1.7	- -	- -
Homemaker	1.7	4.3	3.4
Other	18.9	19.2	22.7
Total	58	114	88

The final topic to be considered in this discussion focuses on the type of job held by type of disability, as shown in Table 43. As one would expect there are substantial differences. Those clients who had orthopedic or vision problems as their major disabilities are found disproportionately in clerical and professional positions. To a lesser extent those with speech difficulties are also overrepresented in the clerical positions. Those with hearing, psychosis, mental retardation and psychological disabilities are overrepresented among the unskilled workers, but it is only the mentally retarded that have a very large proportion in unskilled jobs. Nearly six out of ten of the mentally retarded hold unskilled jobs. Among the other disabilities the proportion does not exceed one in four.

Viewed from a somewhat different perspective, we find that two-thirds of the clients with orthopedic disabilities obtained jobs above the unskilled level. Approximately half of those with vision, hearing, or speech disabilities also obtained jobs at this level. However, the proportion declines to only 40 percent among those in the psychosis and psychological categories and to only 23 percent among the mentally retarded. Again it is noted that these findings must be viewed with caution since the jobs reported represent only the first job obtained at the time of closure. We do not have any evidence on how effectively these people are performing on the job nor do we have any evidence on job turnover or eventual job mobility. Nonetheless, the evidence is clear that at least initially the clients have been successful in entering the labor force. Thus the goals of the Project have been met. The Project appears to have been effective in preventive rehabilitation. It has accepted young adults at an early age with a wide range of disabilities and has, through the treatment provided, equipped them for positions in the labor force which would make them self-supporting. In the years to come when many more clients who are currently in the program become of labor force age, it will be possible to make a comprehensive evaluation of the effectiveness of the Project. At this particular time a large number of the clients have already made a successful adjustment to life and are currently attending high school or college. At least tentatively it would seem that the goals of the Project are being realized. That there are large numbers in the population, at various socio-economic levels, in need of help is evident from the widespread use that has been made of the Project. There is need, however, for a continuous assessment of what is being accomplished. This report represents one such effort.

TABLE 43.

OCCUPATIONAL DISTRIBUTION BY TYPE OF DISABILITY

Occupation	Orthopedic	Vision	Hearing	Speech	Psychosis	Retardation	Psychological
Total Number	136	60	65	30	125	224	314
Professional	14.0	6.7	1.5	6.7	2.4	- -	4.8
Clerical	30.1	30.1	13.8	20.0	12.0	2.7	10.8
Sales	1.5	6.7	3.1	6.7	2.4	- -	3.2
Skilled	11.8	3.3	6.2	10.0	7.2	5.8	8.9
Semi-Skilled	8.8	5.0	17.0	3.3	16.8	12.1	11.5
Unskilled	18.4	25.0	26.2	23.3	19.2	57.6	24.5
Self-Employed	- -	- -	- -	- -	- -	- -	1.3
Homemaker	2.9	5.0	7.7	6.7	10.4	4.0	4.1
Other	11.8	18.3	21.5	23.3	28.8	16.1	30.6

SUMMARY AND CONCLUSIONS

This Project represents a sharp break from the traditional function concerning vocational rehabilitation. In the past attention had been focused largely on corrective measures after the disability proved to be a serious handicap in obtaining a position in the labor force, whereas this program focused on preventive rehabilitation. By this is meant that efforts were made to identify potential problems at an early age and to offer treatment while the client was still a dependent and thus was not yet of age to enter the labor force. The purpose of the Project was to correct the disability so that when the client reached labor force age he will be prepared for regular employment and will be able to be self-supporting.

To accomplish this goal the DVR counselor worked through the schools. On a regular scheduled basis he visited the schools in the area and accepted referrals of potential clients after they had reached their fourteenth birthday. In addition to the traditional physical disabilities, the program also accepted clients with emotional and other psychological disturbances which could lead to a disability which might be expected to make adjustment to a job difficult.

After the clients had been referred to the DVR counselor by the school, they received an extensive diagnostic examination. Those whose problems were evaluated as being in need, and who were likely to benefit from the type of services provided, were accepted for treatment. The treatment available covered a wide range and, for the most part, was not provided by the agency itself but was purchased by the Division of Vocational Rehabilitation in the community. It was the responsibility of the agency, through the counselor and consultants, to determine the type of services needed and then to arrange for the client to have access to these services. In this way the agency was able to identify problem cases at a young age and provide preventive treatment before the problem reached an advanced stage of development. Experience has shown that nearly all of the clients that had been accepted by the agency had taken advantage of the services provided. The high use rate suggests that this method of identifying clients in need of services was very effective. In this Project the DVR counselor was the crucial link. It was his responsibility to identify the clients and then bring together a wide variety of medical and paramedical specialists and services to meet the rehabilitative needs of the clients that were accepted for treatment.

During the life of the Project more than 5,000 teenagers had been referred to the agency for a wide range of disabilities. The number of referrals increased as the Project became more widely known and accepted in the schools. The results of this Project clearly demonstrate that this type of program can effectively work through the schools. In actual practice it was a supplement to the schools. It provided an outlet for those cases where the schools did not have the facilities to provide the type of treatment that was needed. The Project had been well received in the schools and widespread use had been made of the services that were offered.

One of the central problems in the day-to-day functioning of the agency had been the high turnover among the counselors. Since the counselor does play a crucial role, the efficiency of the Project declined when a counselor left and a new one took over his case load. The close working relationship that had been established with the client through extended contact was not easily developed by his replacement. Experience has shown that the counselors tended to move on to more attractive jobs, that is, jobs with higher incomes. That the agency was not able to retain the experienced counselors results from the inability of the agency to compete in terms of the salaries the counselors can obtain elsewhere. Many of the counselors who left the Project reported that they found the job challenging, interesting and rewarding, but they found it necessary to move on to another job in order to improve their income.

While the focus of this Project had been quite different from the traditional function of the agency, it merely means that the same type of services and know-how of the regular agency had been extended to a different segment of the population. While the referral system differed and the School Project catered to a different type population, the general procedure for providing diagnostic and treatment services remained the same.

In catering to the young adults, the agency was providing a vital service to the schools and to families throughout the state that ordinarily would not be able to provide, through their own resources, the type of treatment that was needed. The fact that so many of the families took advantage of the program not only demonstrates the need for such services, but also suggest that families with children that have problems are eager and willing to obtain professional assistance in an attempt to overcome these problems.

How effectively the Project functioned depended in large part on the quality of the DVR counselor and how well he interacted with the school guidance counselor. The evidence on this was consistent. As the quality of the counselor increased, the proportion of the eligible population served also increased. One of the qualities of the better counselors was their dependability and regularity in visiting the schools. The excellent counselors also had empathy and a high level of interest in what they were doing. When the school guidance counselors were interviewed regarding the Project, the point was made over and over again that it was absolutely necessary for the DVR counselor to be consistent and regular in his visits to the school. In the few cases where the DVR counselor failed in this respect, where the counselor had the reputation of breaking appointments, the proportionate use of the Project declined substantially.

It was also found that the Project was most successful in those schools where the DVR counselor and the school guidance counselor related effectively to each other. Thus it is not only the quality of the DVR counselor that is important, but the compatibility of the DVR counselor and the school guidance counselor was also a major factor in how effectively the Project reached the eligible population. Even when a high quality DVR counselor was not able to relate successfully to the personality of the school guidance counselor, the use of the Project dropped off.

In our efforts to evaluate the accomplishments of the Demonstration Project it became readily apparent that the traditional methods of using "closed employed" as a measure of success was not really applicable in this program. Since the clients were referred at a very young age (most referrals were made when the client was under 16 years of age), years would have to pass before the client would finish school and be old enough to enter the labor market. With the "closed employed" method of measuring success it was not possible to show a record of accomplishments. When the work of the school counselors was evaluated within the regular agency, it would necessarily follow that their "successes" would be low in relationship to the size of their caseload. This, of course, is misleading. Clearly one measure of "success" in this program was to keep the client in school. The more successful the counselor was in accomplishing this goal, the lower his "closed employed" would be until the clients had completed their education. Thus, according to the traditional criteria, the better counselors were likely to have poor performance records. There is a need to develop a new criteria for measuring success on this program. Perhaps this could be done by having periodic reviews of the counselors' caseload and a determination made as to whether the client was making progress. Techniques need to be developed to measure whether or not the client was responding to treatment. This would provide the agency with an on-going evaluation of what was being done and would also provide the counselor, at least periodically, with some index of accomplishment.

A comparable problem also exists on the regular program. For example, a client with a chronic disability may require years of costly treatment concurrent with his full participation in the labor force, but because of the long range treatment needs he would not become a "closed" case, even though he was fully employed. He would remain an active case. Clearly, in such instances the agency is providing a vital service. However, current methods of record keeping do not give this type of service the recognition it deserves. Such cases can place a heavy economic burden on the agency but the needs are such, and the returns are such, that the expenditure is fully justified. There is a real need to develop a method of reporting which would give credit for this type of service.

In conclusion, it would seem that the need for this type of Project is evident by the use that was made of it. During the course of the Demonstration Project more than 5,000 youngsters with a wide range of disabilities were referred to the Project and offered assistance. Preventive rehabilitation is impossible to measure since there is no way to know what would have been the outcome without treatment, but at least we know that thousands of young people throughout the state had problems serious enough in nature to warrant referral to this agency, and they were offered and accepted a wide range of services. Regardless of the outcome, an effort was made. Only time and the individuals involved can demonstrate the effectiveness of the Project.